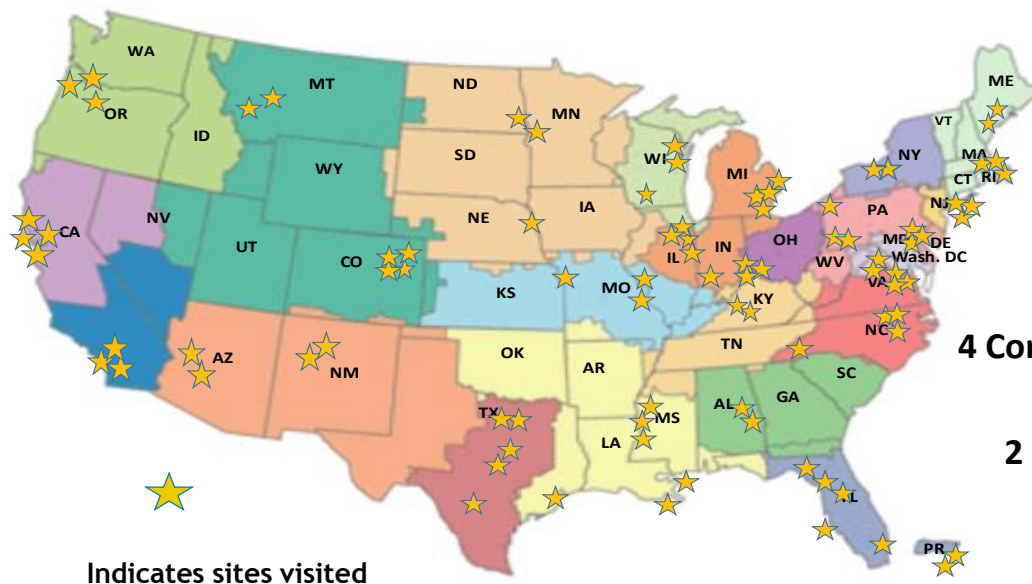


Veterans Access, Choice, and Accountability Act of 2014 - Section 201 - Independent Assessment

September 21-22, 2015



Assessment Efforts



87 site visits
39 VA Medical Centers
13 VISNs

23 Community Based Outpatient Clinics
4 Construction and Facilities Management Offices
2 Acquisition Centers
2 Consolidated Mail Outpatient Pharmacies
3 Consolidated Patient Account Centers
6 active major construction sites

- Analysis of 560 VA provided data sets plus other data sets available from multiple sources
- 5 individual-level data calls & surveys to staff at VHA sites
- Analysis of 137 previous assessments, including Institute of Medicine Assessment D (Access Standards) report

- Convened Independent Blue Ribbon Panel
- Engaged 27 Health Care Leaders
- Engaged 8 Veteran Service Organizations
- Visited 4 High-Performing Health Care Organizations

GEISINGER

 Cleveland Clinic

 KAISER PERMANENTE


Virginia Mason



Limitations and Gaps

▪ *Limitations*

- Could not visit every Veterans Affairs Medical Facility.
- Unable to audit VHA data; assumed quality, reliability, and accuracy of VHA data were acceptable.
- Restrictions under the Paperwork Reduction Act precluded the design and implementation of a formal survey of all Veterans
- Central data unavailable in many domains, necessitating dependence on locally generated data and interviews.

▪ *Gaps* - legislation timeframe and requirements did not support

- The exploration of cost and the assessment of value.
- The evaluation of VA's methods for measuring and projecting demand for health care.
- A complete examination of purchased care; specifically the quality of care provided in the community and paid for by VA, the ability of Veterans to access such care, or the cost of such care relative to care provided in VA facilities.
- An exploration of options to enhance collaboration with DoD
- An assessment of VA Care coordination efforts
- An analysis of
 - Outpatient workflow
 - Nursing staffing levels
 - Audits of payments, audits of provider time at affiliates
 - Accuracy of coding

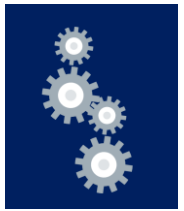
First Systemic Finding – Governance



A disconnect in the alignment of demand, resources, and authorities

- VA lacks enduring ***governance model*** for long-term guidance, direction and accountability.
- ***Tenure of leaders*** in key positions is tied to election cycles impacting those leaders' stability and longevity.
- VA is required to manage to the budget regardless of the level of demand, and has limitations that hinder the ability to ***assess how demand*** for VA services may change over time:
 - VA's authorities for furnishing care are complex and scattered, they embody more than one aim and they lead to confusion among providers, local VHA facilities and Veterans.
 - Difficult to generate a comprehensive overview of Veteran reliance on VA, defined as the share of health care services that VA patients receive from VA versus from other sources.

Second Systemic Finding - Operations



Uneven bureaucratic operations and processes

- VA's **contracting processes** are bureaucratic and slow motivating extensive workarounds at local VA facilities; VA's supply chain organizational structure is complex and duplicative.
- **Call centers** are small, uncoordinated, independent operations at the local level offering disparate services, prohibiting the benefits that centralized call centers enable.
- VHA's complex and disparate processes for **paying non-VA care claims** are confusing to Non-VA providers and VHA staff resulting in inconsistencies in authorization and payment practices.
- **Hiring timeline** significantly exceeds private-sector benchmarks, affecting VHA's ability to fill vacancies on patient care teams.
- Pockets of best practices and innovation exist, but the adoption can be isolated even within the same facility. **Best practices** not systematically shared and adopted across VISNs and VAMCs.

Third Systemic Finding – Data and Tools



Non-integrated variations in clinical and business data and tools

- VHA's **EHR** issues stymie interoperability between VHA facilities as well as with DoD and non-VA providers.
- **Scheduling** appointments challenged by lack of accurate visibility into supply of available appointments, inhibits VHA's ability to effectively match patient requirements to provider availability.
- Lack of integration and interoperability between **billing systems** and tools slow billing activities and introduce potential errors as staff are required to enter redundant data into different systems.
- **Claims payments** burdened by lack of automation, non-integrated systems and significant manual input; precludes timely and accurate data and results in payment errors and delays in claims payment.
- Current suite of options and **navigational tools** to explore benefit options has proven challenging.
- VHA lacks a clear strategy to effectively apply data and metrics to **performance improvements**; including distilling and prioritizing metrics to drive patient-centered outcomes.

Fourth Systemic Finding - Leadership



Leaders are not fully empowered due to lack of clear authority, priorities, and goals

- An expanding scope of VHA activities has led to ***confusion around priorities and strategic direction.***
- VHA leadership do not feel they have the ***authority*** to perform their role in the current environment; an increase in centralized control that was intended to mitigate risk has, in fact, constrained leadership authority.
- VHA organization is ***intensely, unnecessarily complex*** due to lack of a clear operating model, limited role clarity, fragmentation of authority, and overlapping responsibilities.
- Broader VHA culture characterized by ***risk aversion and distrust***, resulting in an inability to improve performance consistently and fully across the system; leaders must feel safe.
- An anemic ***leadership pipeline*** that will not support VHA's current and future needs.

Four Overarching Recommendations

Governance



A disconnect in the alignment of demand, resources, and authorities

Align demand, resources and authorities.

Operations



Uneven bureaucratic operations and processes

Develop patient centered operations model that balances local autonomy with appropriate standardization and employs best practices for high quality health care.

Data and Tools



Non-integrated variations in clinical and business data and tools

Develop and deploy a standardized and common set of data and tools for transparency and evidence-based decisions.

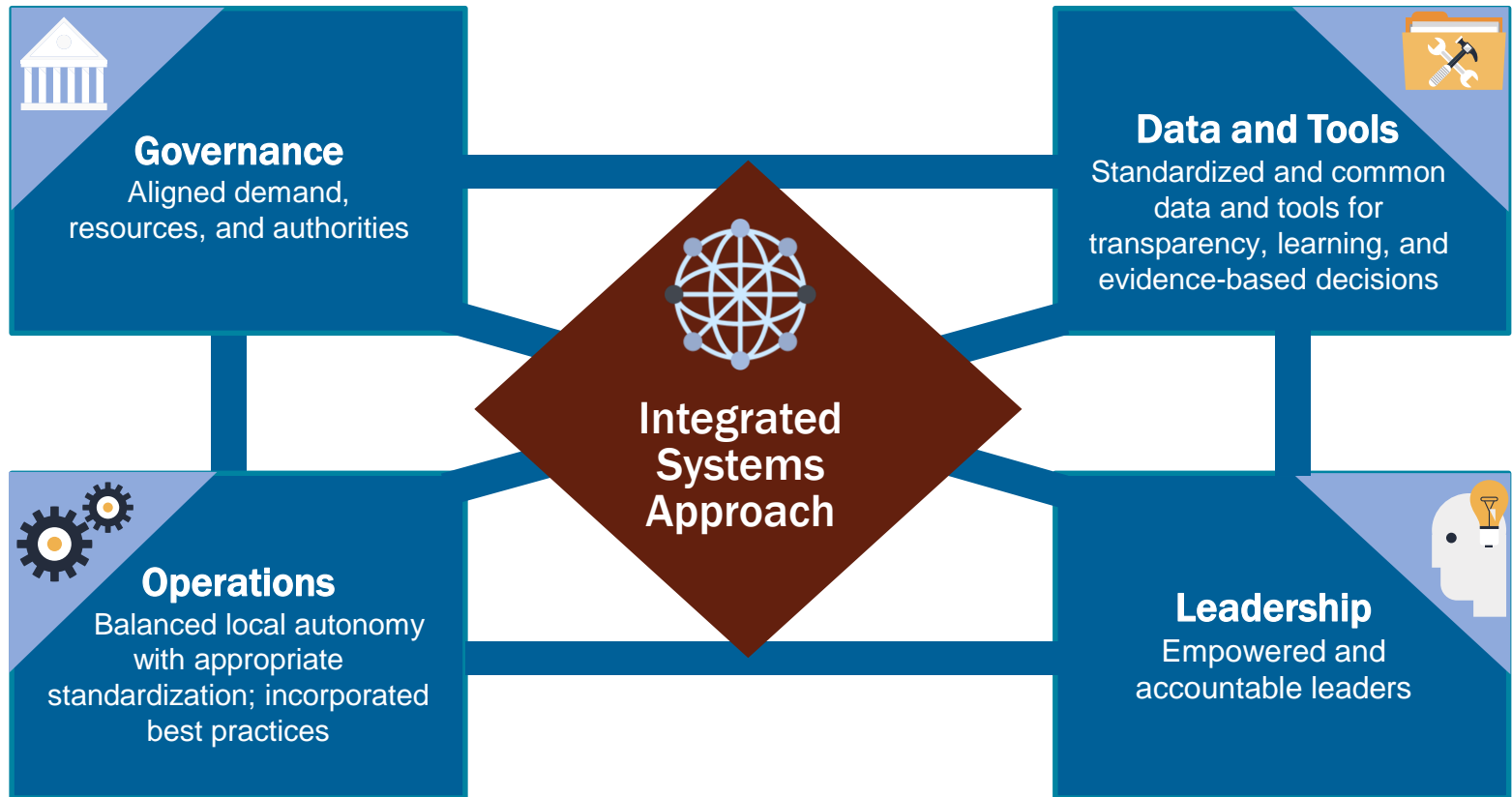
Leadership



Leaders are not fully empowered due to lack of clear authority, priorities, and goals

Stabilize, grow and empower leaders; galvanize them around clear priorities; build a healthy culture of collaboration, ownership and accountability.

Integrated Systems Approach



Access Challenges through the Lens of the Integrated Systems Approach



Governance

- Congress stipulates appointment wait times as the access metric.
- Lack of governance commitment on basic access principles.
- Current governance approach does not ensure system-wide standards are developed, proposed, tested and appropriately applied based on local conditions.



Data and Tools

- Patient access metrics do not effectively include data on patient experience, scheduling practices, patterns and wait times, cycle times, and care continuity.
- Real-time capacity data not available to identify requirements.
- Definition of a patient encounter precludes exploiting alternative engagement approaches (non-physician clinicians, technology mediated consultations).



Integrated Systems Approach



Operations

- Evidence-based best practices not fully identified and exploited.
- Approaches do not balance supply and demand, limited ability to modulate capacity, or implement surge contingencies to include technology-based alternatives to in-person visits.
- Substandard processes in patient scheduling; lack of centralized call centers.



Leadership

- Systems approach not fully embraced and employed.
- Delays in access not adequately addressed by all relevant stakeholders across care continuum; tendency to opt for piecemeal process changes.
- Facility leadership not fully focused on continuous assessment and adjustment at each care site.

Access Solutions through the Lens of the Integrated Systems Approach



Governance

- Adopt and endorse system-based best practice metrics.
- Clarify and simplify the rules for purchased care.
- Evaluate PACT to determine whether primary care staffing guidance and PACT implementation are sufficient to meet demand.



Data and Tools

- Develop actionable patient access metrics, including patient and family experience data, scheduling practices, patterns, wait times, cycle times, and care continuity.
- Develop and implement staffing models for outpatient specialty clinics to optimize staffing and meet demand.
- Exploit other modes of patient encounter to include non-physician clinicians, technology mediated consultations.



Integrated Systems Approach



Operations

- Identification and use evidence-based best practices, both internal and external.
- Balance supply and demand, limited ability to modulate capacity, or implement surge contingencies to include technology-based alternatives to in-person visits.
- Adopt processes in patient scheduling; create centralized call centers.



Leadership

- Commit to a systems approach.
- Specify accountability that would ensure delays in access are addressed by all relevant stakeholders across care continuum, rather than with piecemeal, independent process changes.
- Facility leadership should focus on continuous assessment and adjustment at each care site.

Facilities Challenges through the Lens of the Integrated Systems Approach



Governance

- Constraints limit ability to operate medical facilities at level of private-sector benchmarks and to accommodate future trends.
- Facilities Investments not linked to workload growth; existing space not used at highest efficiency; hard to eliminate underutilized space.
- Expected funding levels do not support identified capital needs.



Data and Tools

- Data capture occurs at multiple levels with multiple tools, generating multiple sources of truth about capital program.
- Tools for developing Strategic Capital Investment Plan business cases rely on individual effort versus a systematic process to consider creative alternatives.
- Systems do not consistently capture key standardized performance indicators.



Integrated Systems Approach



Operations

- Lengthy approval & funding timelines hinder ability to invest in appropriate upgrades and meet space requirements.
- No integrated system to manage entire leasing process.
- Large majority of facilities challenged to fill vacant positions when budget is allocated.
- Scope and design criteria frequently subjected to major changes.



Leadership

- Shortfalls in accountability, role clarity, personal ownership, internal communication, and proactive problem-solving approaches.
- Facilities culture characterized by silos, risk aversion, and role ambiguity.
- Competition for limited funds has led leaders to make sub-optimal choices that favor approval over efficient delivery.

Facilities Solutions through the Lens of the Integrated Systems Approach



Governance

- Create Governance Board with authorities to:
 - Realign facilities investments
 - Authorize appropriate closures.
- Explore alternative vehicles for capital delivery.



Data and Tools

- Capture data at multiple levels with one tool, to generate one source of truth about capital program.
- Create systemic tools for developing Strategic Capital Investment Plan business cases to consider creative alternatives.
- Create systems to consistently capture key standardized performance indicators.



Integrated Systems Approach



Operations

- Improve project selection; refine the process.
- Streamline project delivery.
- Maximize operational efficiency.
- Scope and design criteria frequently subjected to major changes.



Leadership

- Clarify accountability, role clarity, personal ownership, internal communication, and proactive problem-solving approaches.
- Eliminate silos, risk aversion, and role ambiguity.
- Realign incentives to support choices that promote efficient delivery.

IT Challenges through the Lens of the Integrated Systems Approach



Governance

- Inadequate collaboration between VA's centralized IT organization & VHA results in failure to prioritize IT capabilities that will support VHA health care needs.
- Lack of a robust, detailed strategy and roadmap for scheduling initiatives across VA to integrate Veteran scheduling via all modalities.
- Lack of dedicated VHA IT executives.



Data and Tools

- Lack of patient access metrics, including data on patient & family experience, scheduling practices, patterns & wait times, cycle times, & effective care continuity.
- Lack of real-time capacity data.
- Definition of a patient encounter precludes exploiting alternative engagement approaches (non-physician clinicians, technology mediated consultations).



Integrated Systems Approach



Operations

- Document-centric, schedule-focused project management and execution processes that preclude delivery of needed capabilities.
- Challenges in building and maintaining a skilled health informatics workforce
- Lack of technical support to Veterans for home telehealth.



Leadership

- Internal project-focused central IT service management philosophy vice customer focused.
- VA CIO turnover precluded enduring, coherent approach to consolidate new infrastructure technologies, resulting in even greater software complexity.
- VistA program organization and staffing lacking; precludes successful management, development, and integration.

IT Solutions through the Lens of the Integrated Systems Approach



Governance

- Lengthen tenure of key leadership positions, including VA CIO
- Designate a dedicated VHA CIO to manage and advocate VHA's IT needs



Data and Tools

- Perform a comprehensive cost-versus-benefit analysis between a commercial off the shelf EHR and continued in-house custom development of VistA EHR
- Create real-time data capacity with standardized enterprise data to enable analysis of trends, best practices, and efficacy of new treatments
- Implement standardized data exchange with DoD, payers, and private providers



Integrated Systems Approach



Operations

- Implement a broad process, inclusive of clinicians, to pursue requirements that support clinical documentation best practices and improved functionality
- Build and maintain a skilled health informatics workforce
- Enhance technical support to Veterans for home telehealth
- Publish limited, strategic measures (e.g., access, quality, satisfaction)



Leadership

- Convert project-focused IT approach to IT service management model with customer focus
- Create effective VistA program organization and staffing
- Develop decision support capabilities that monitor quality, patient satisfaction, claims, payments, access, supply, and demand



Implementing the Integrated Systems Approach

- Senior VA leadership should
 - Embrace a **systems approach** philosophy that recognizes the interdependence of the four cornerstones.
 - Subsume ongoing change initiatives and merge relevant components of MyVA and the *Blueprint for Excellence* into **one VA-focused systems-based transformational approach**.
 - Require **evidence-based systems models** to inform and implement integrated solutions balancing governance, operations, data and tools, and leadership.
 - Provide **dedicated funding** (redirected from current central and local funding mechanisms) to enable the integrated systems approach.
 - Charter a lean and focused **Transformation Program Management Office** with the authority to drive the system-wide reworking of VHA by
 - Communicating the aspirational state, establishing priorities, defining execution timelines, implementing strategic and tactical initiatives, allocating resources, and instituting metrics and processes to measure progress and success.

*Research has found that projects that add value, are completed on-time, and fully meet business objectives occur less than 25% of the time. While attention to the objectives and form of the new design is common, much less consideration is given to **designing and executing the plan**.*



Enabling the Integrated Systems Approach

- Congress should
 - Create and endorse a **long-term governance board** to develop fundamental policy, define the strategic direction, insulate VHA leadership from direct political intervention, and ensure accountability for the achievement of established performance measures.
 - Extend the **tenure of key VA leaders** so that it spans presidential administrations and election cycles.
 - *These top leadership positions in one of the nation's largest health care systems could be considered akin to the Internal Revenue Service (IRS) Commissioner position. Congress passed the U.S. Internal Revenue Service Reform and Restructuring Act of 1998. That legislation allowed the IRS Commissioner a five-year term that crossed administrations and provided the opportunity to fully implement the IRS transformation.*
 - Eliminate the **inflexibility in VA budgeting**.
 - Ensure the **2020 Census** captures the full and complete picture of the Veteran population.
 - Approve improved **compensation options** for key leadership roles.
 - Support recommendations from the Commission on **strategies for purchased care** and aligning supply and demand for VA health care.

Reinforcing the Integrated Systems Approach

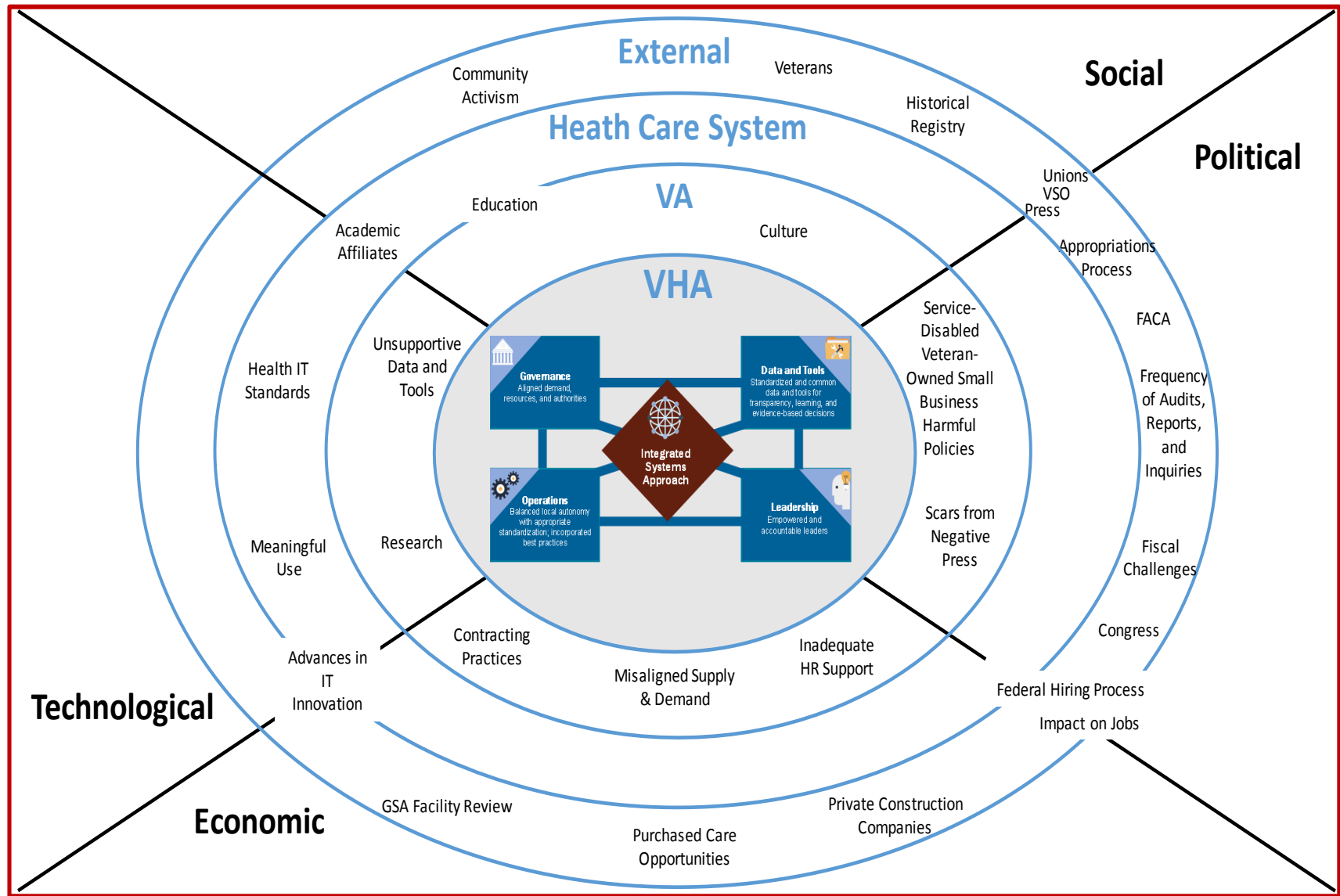
Recommendations from Commission On Care should fall into three categories:

- Category 1 - VHA develop a comprehensive, integrated **transformation plan** with dedicated resources to ensure measurable improvements for the care of Veterans.
- Category 2 - VHA take credible steps towards **implementing key recommendations** from Choice Act to build momentum for the transformation without interfering with the development of the transformation plan.
- Category 3 - Address the **gaps** in the assessment approach, to ensure even more complete coverage of the issues that plague VA.

The Choice Act team will provide some initial recommendations for these categories



The Ecosystem of the Veteran's Health Care System



QUESTIONS or COMMENTS?



“To care for him who shall have borne the battle and
for his widow and his orphan”

Abraham Lincoln



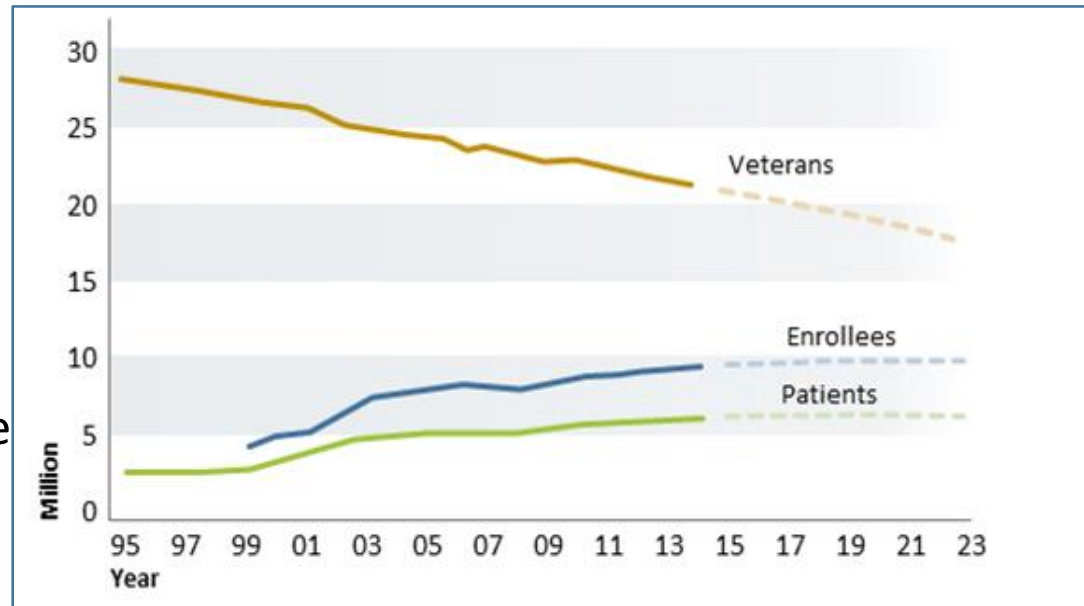
Assessment A: Demographics and Health Care Needs

Conduct an assessment of the “current and projected demographics and unique health care needs of the patient population served by the Department.”

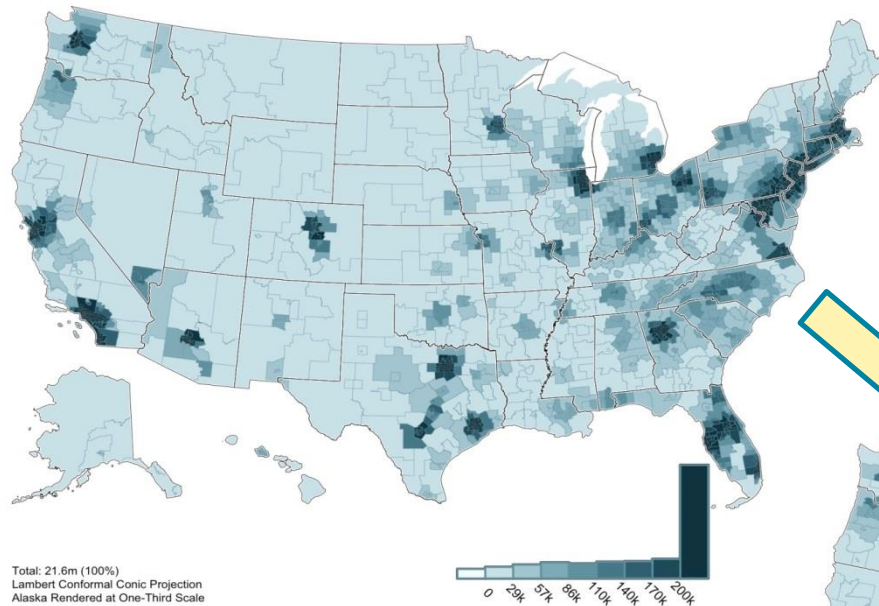
Assessment A: Demographics and Health Care Needs

Summary Findings

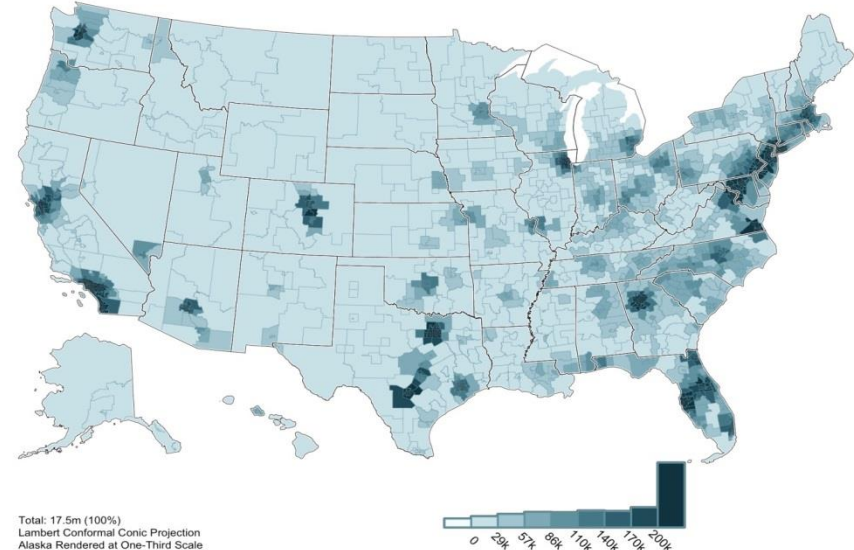
- Veteran population will decrease by 19% by 2024
- 59% of Veterans (12.8M) are eligible to enroll in VA health care
- Half of those eligible use VA care
- Patient population will begin to level off
- Veterans are older and have a higher prevalence of many conditions than non-Veterans
 - Those who use VA are even sicker
 - Prevalence of many chronic conditions will increase by 10-20% among VA patients over the next 10 years



The size and location of the Veteran population will Change over the next 10 years



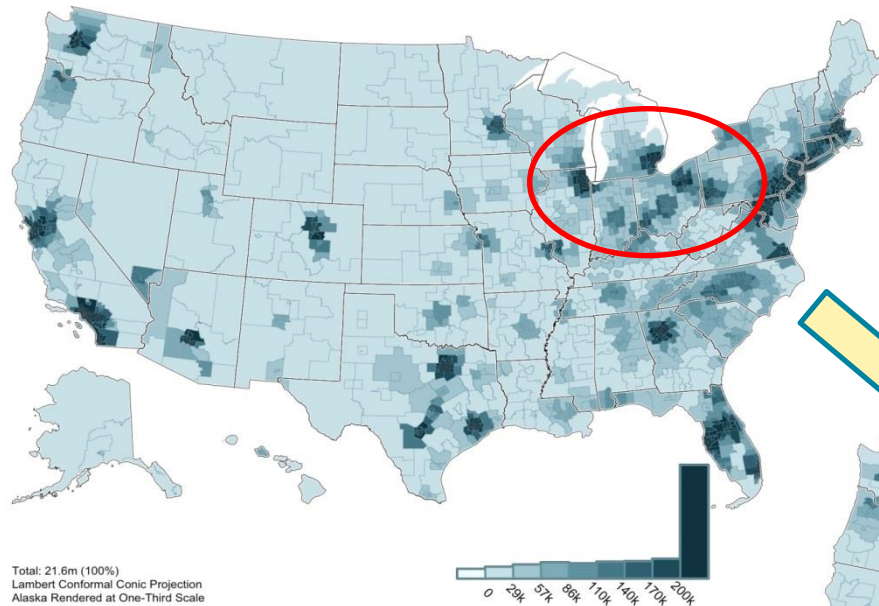
Total Veteran Population 2014



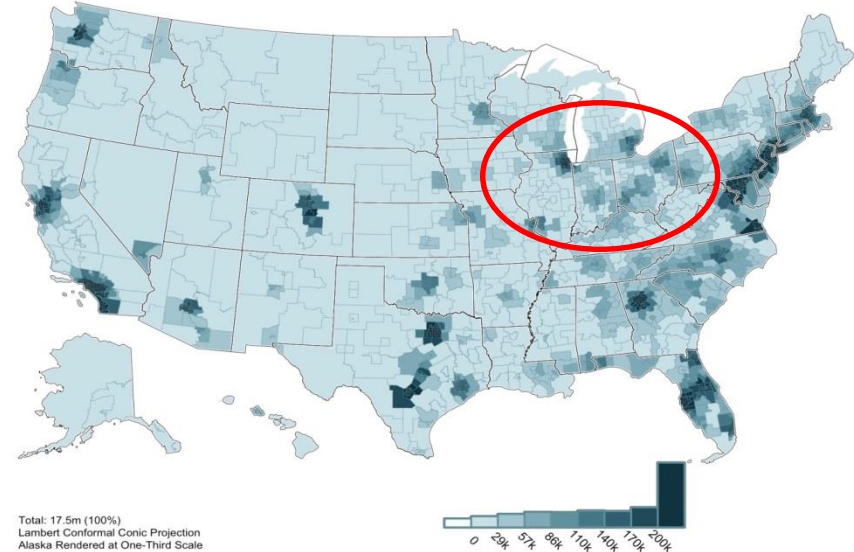
Total Veteran Population 2024

Figures 3-9 and 3-10, Assessment A Report.

The size and location of the Veteran population will Change over the next 10 years



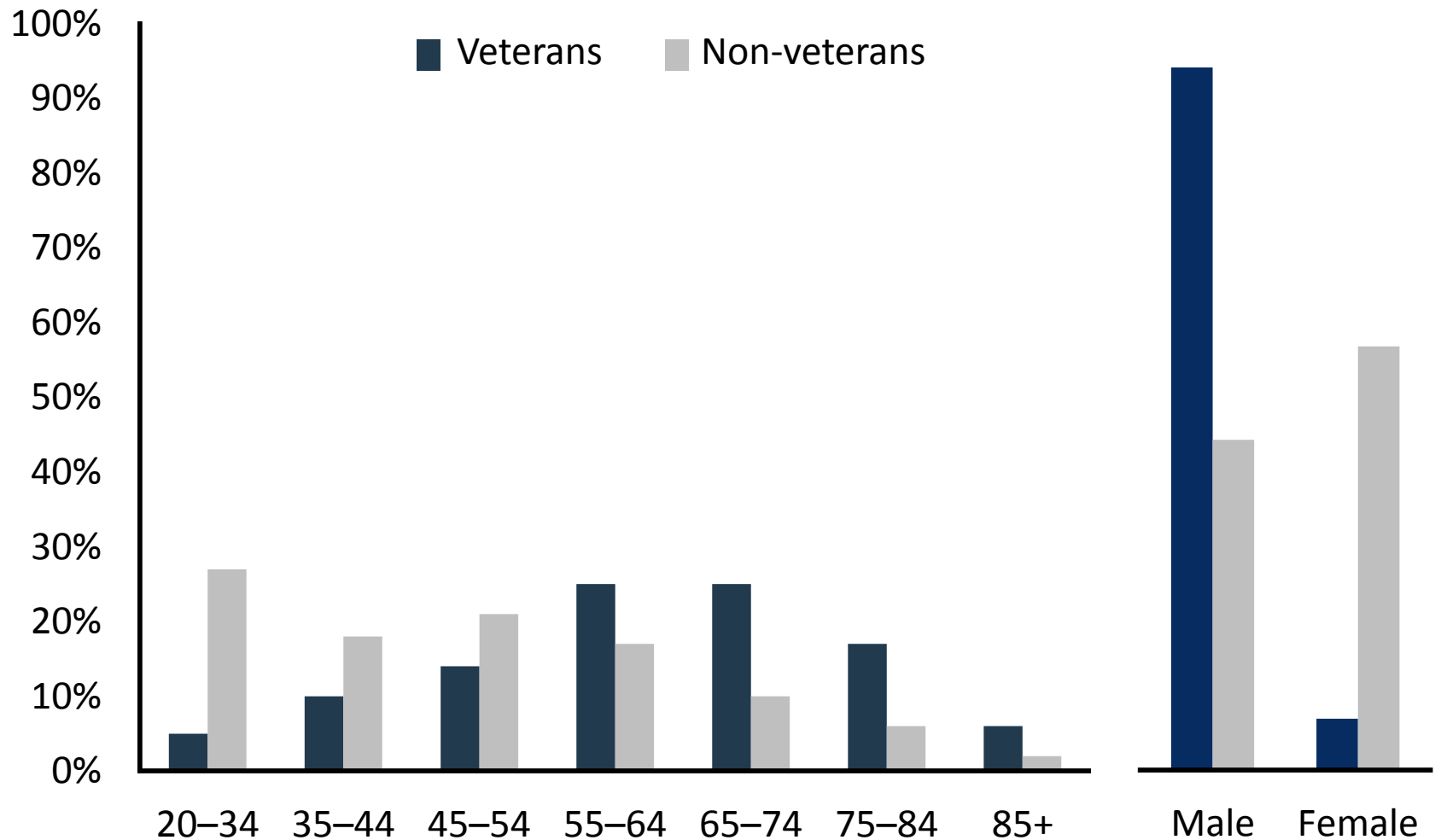
Total Veteran Population 2014



Total Veteran Population 2024

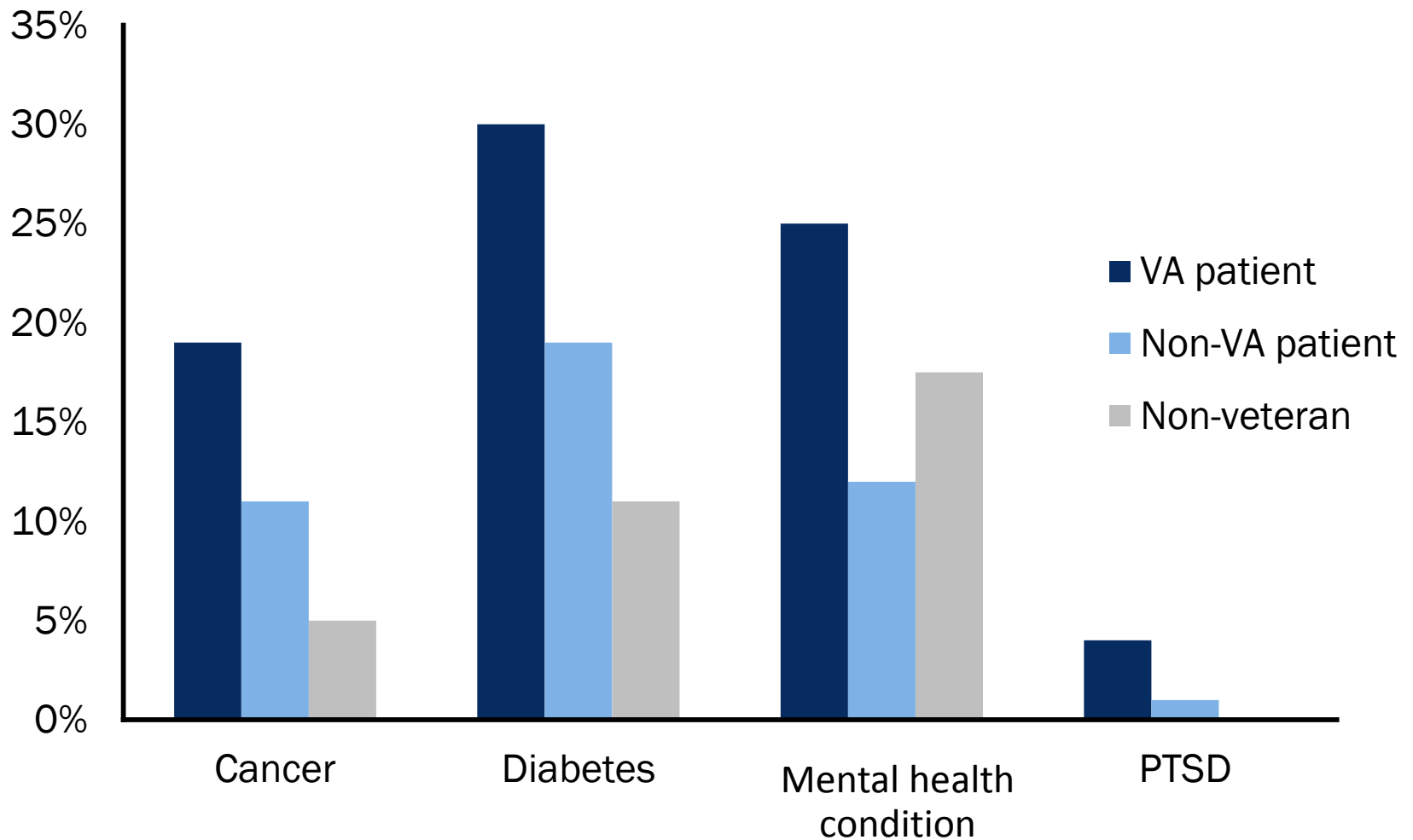
Figures 3-9 and 3-10, Assessment A Report.

Veterans are older than non-Veterans and are disproportionately male



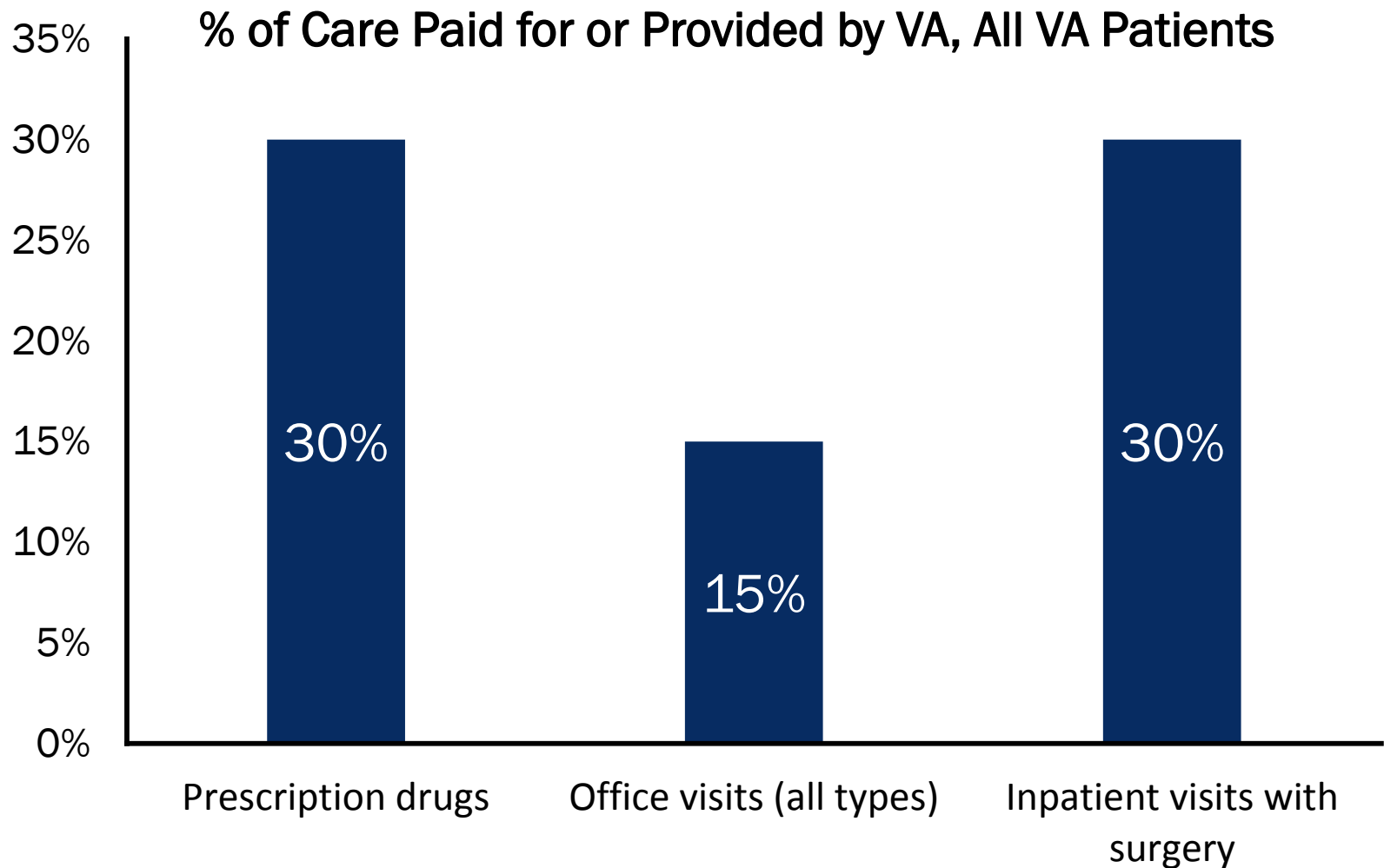
Adapted from Figure 5-1 and Appendix Table B-3, Assessment A Report.

Veterans have a higher prevalence of several key health conditions



Adapted from Figures 5-2, 5-9, and 5-10, Assessment A Report.

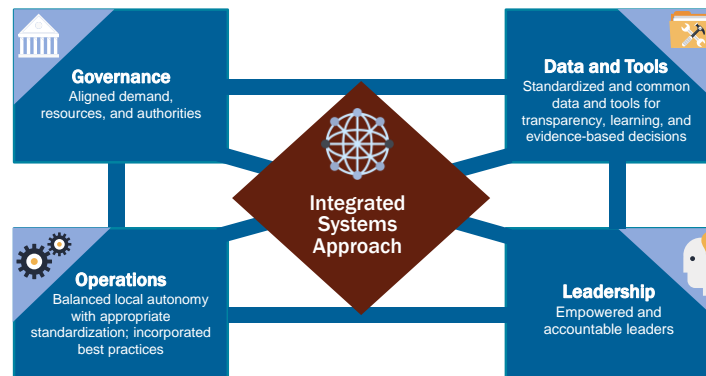
VA patients rely on VA for only some health care needs



Adapted from Figure 4-9, Assessment B Report.

Assessment A Recommendations

- Plan for a changing Veteran landscape
- Anticipate shifts in the geographic distribution of Veterans
- Improve data collection on Veterans
- Improve data collection on Veterans health care utilization and reliance
- Monitor health care use among younger Veterans and Veterans of Iraq and Afghanistan
- Develop analytic framework to perform scenario testing





Assessment B: Health Care Capabilities

Conduct an assessment of the “current and projected health care capabilities and resources of the Department, including hospital care, medical services, and other health care furnished by non-Department facilities under contract with the Department, to provide timely and accessible care to veterans.”

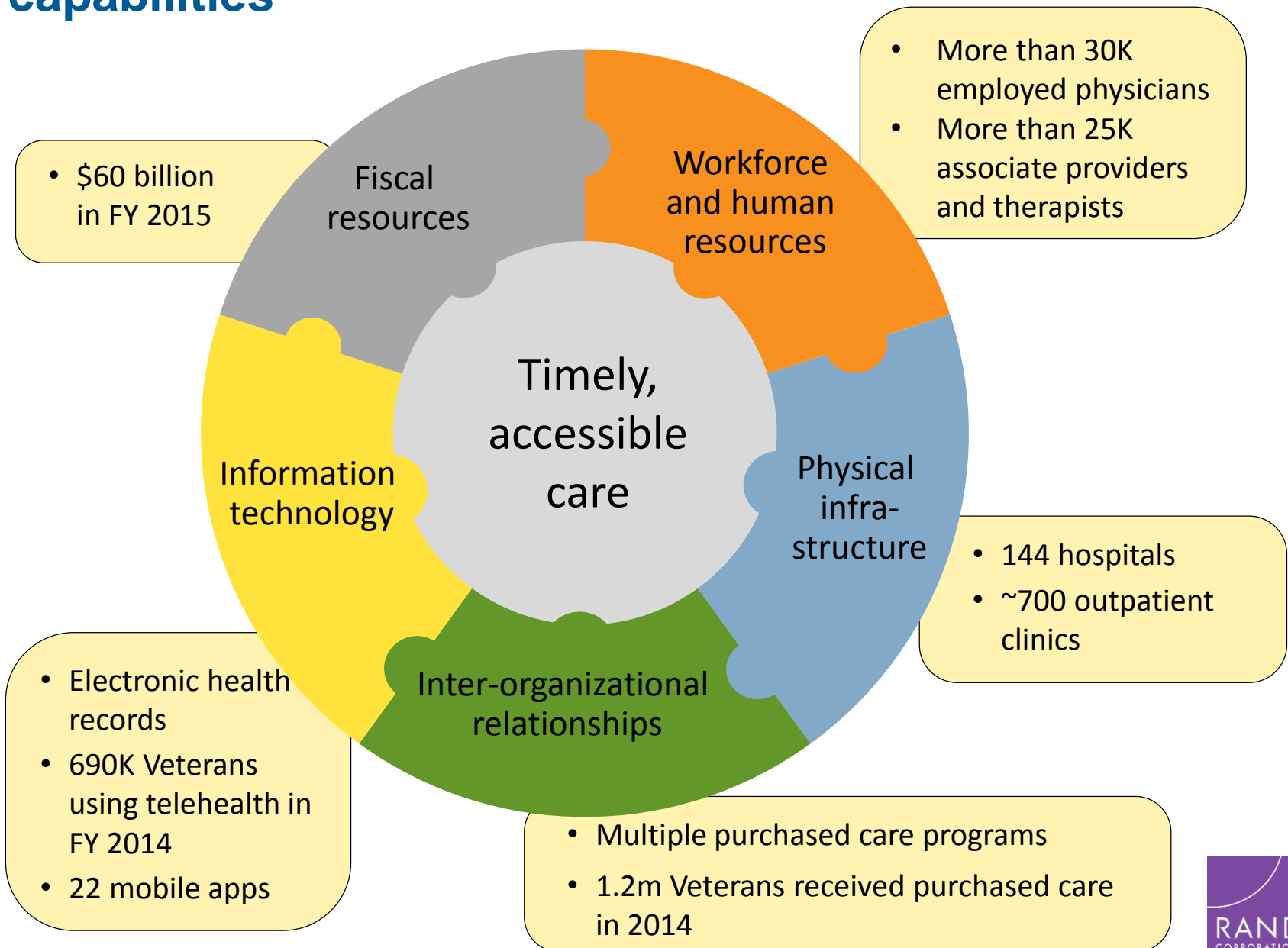


Assessment B: Health Care Capabilities

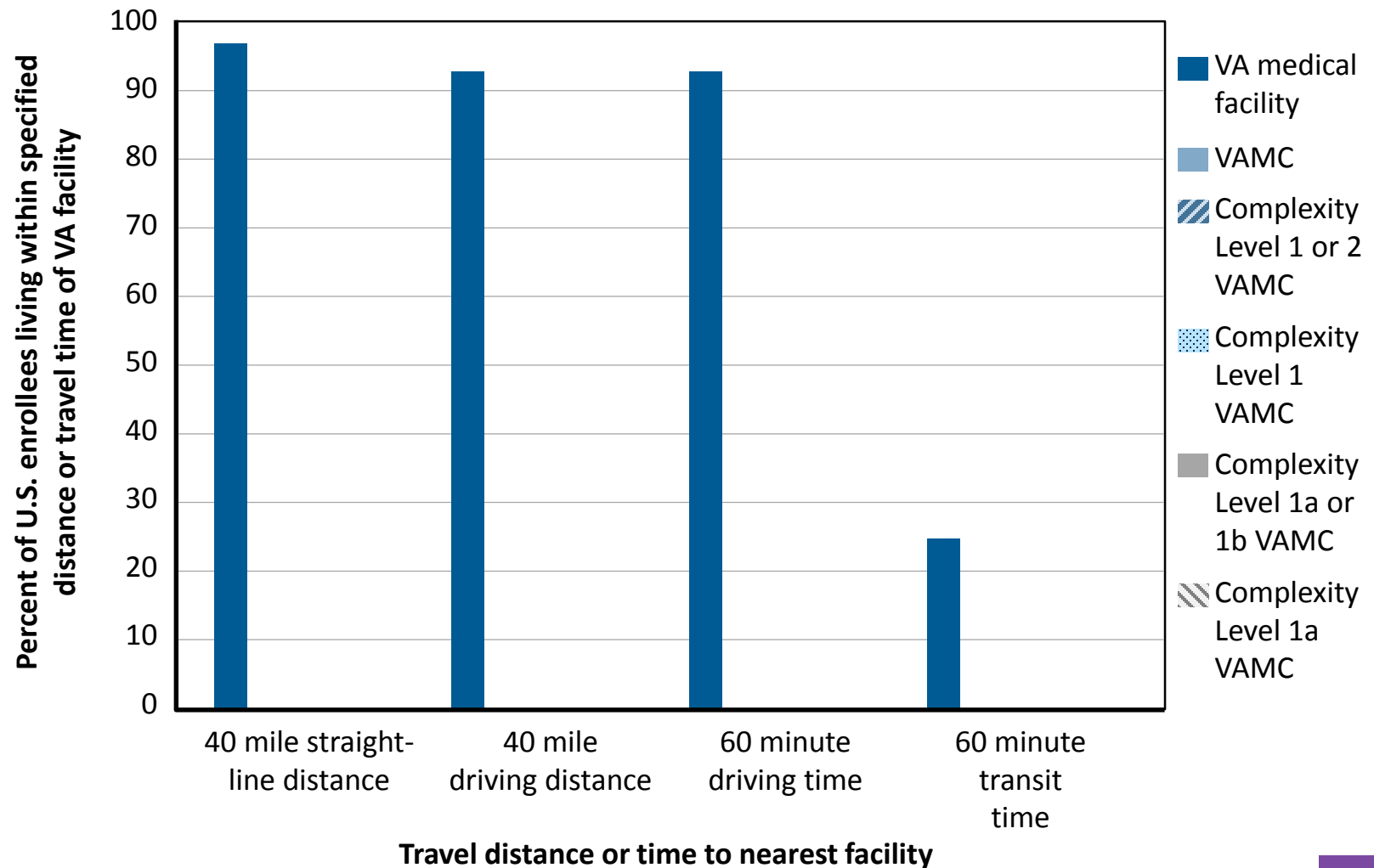
Summary Findings

- VA has broad and deep health care resources and capabilities
- Access and quality are the best measures of VA's capacity to use these resources to meet Veterans' health care needs
- Access to VA health care is good for many Veterans, but not for all
 - Most Veterans live close to a VA facility, but specific health needs and transportation to care matters
 - Appointments average 3-6 days from preferred date, but can be much longer
- Compared to other health systems, VA quality on many measures is good
 - But quality in some facilities and on some measures is lower
- VA will need to take steps to meet demand projected through 2019

VA has broad and deep health care resources and capabilities

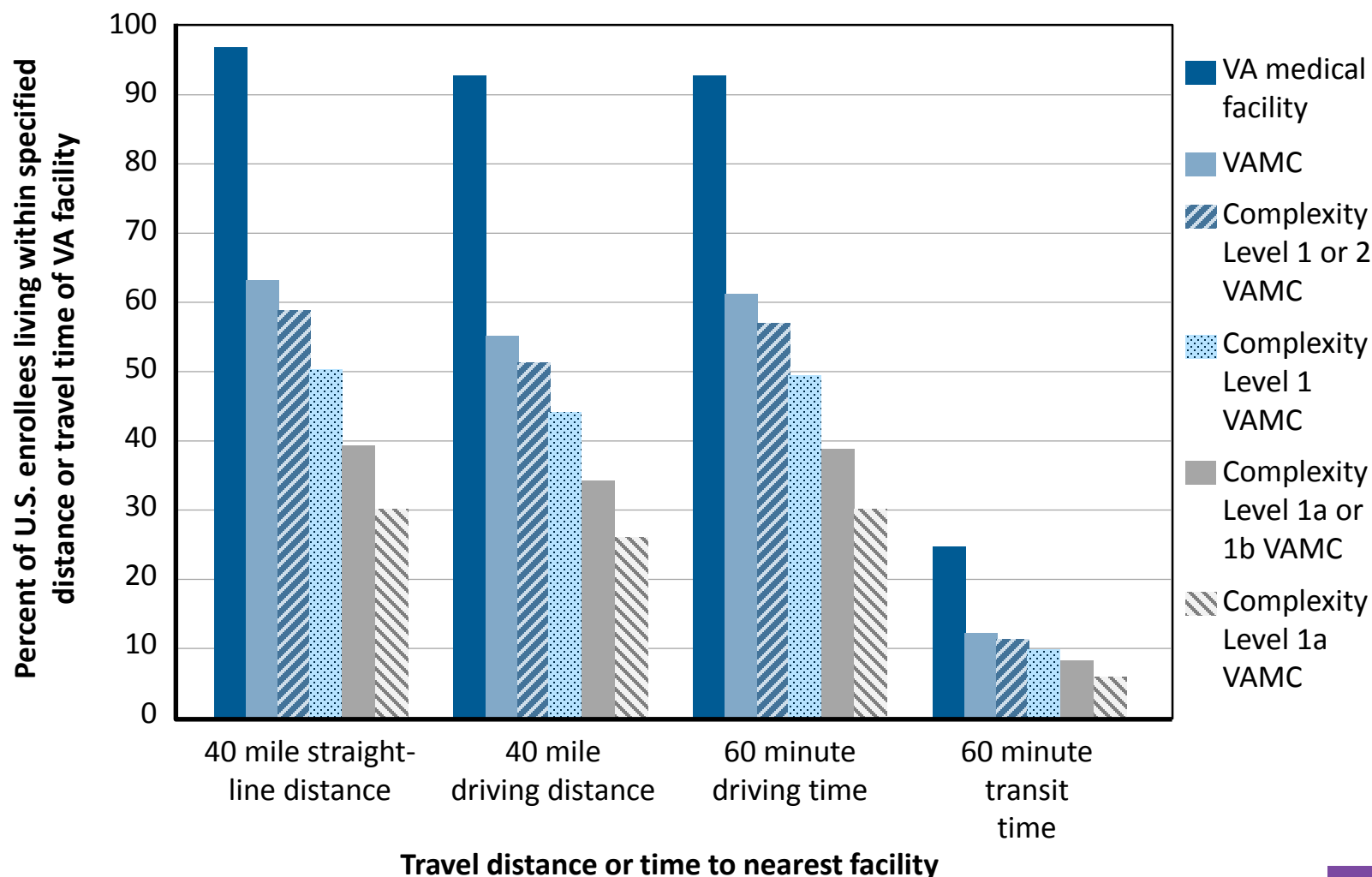


Most Veterans live close to a VA facility, but specific health needs and transportation to care matters



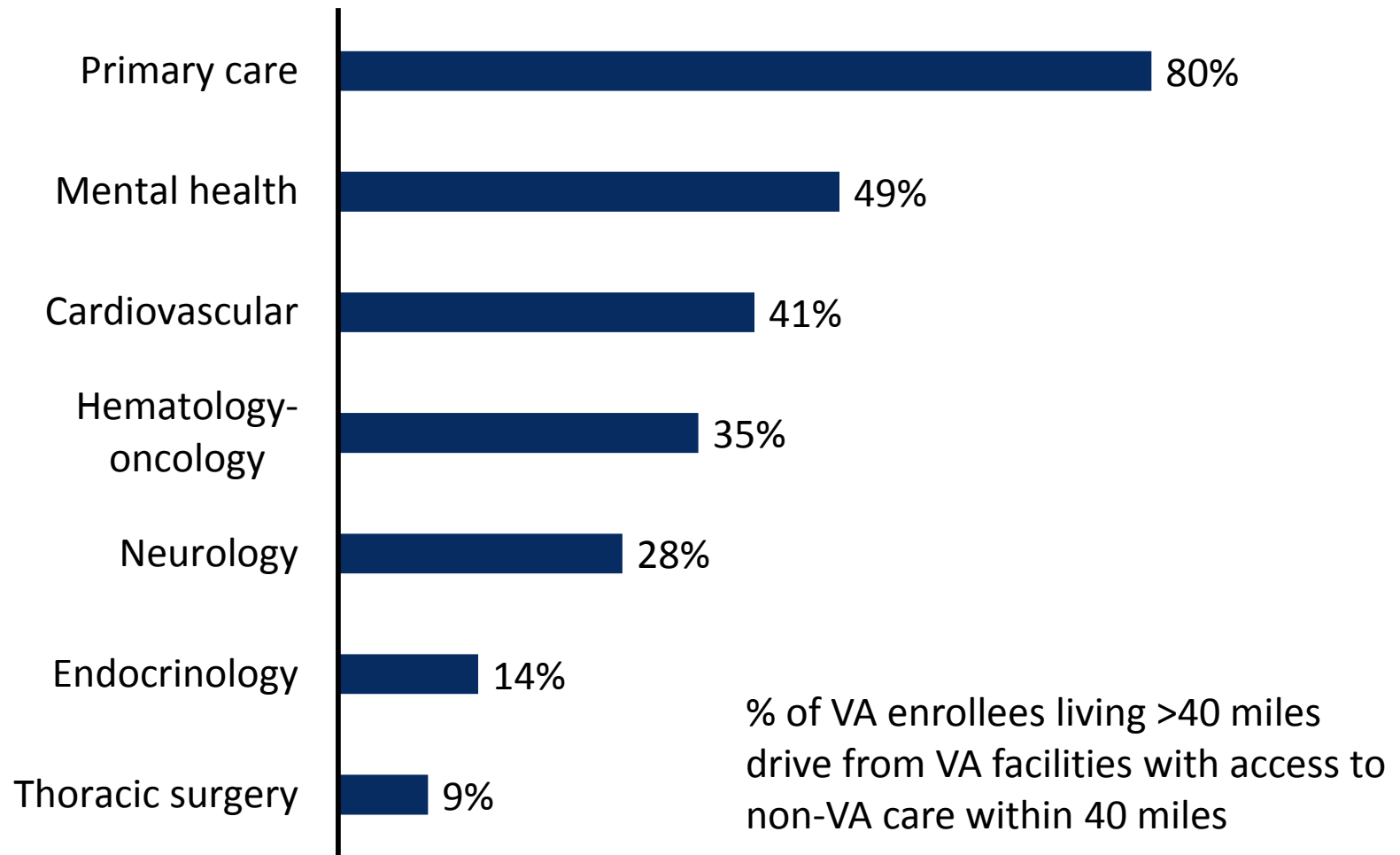
Adapted from Figure 4-4, Assessment B Report

Most Veterans live close to a VA facility, but specific health needs and transportation to care matters



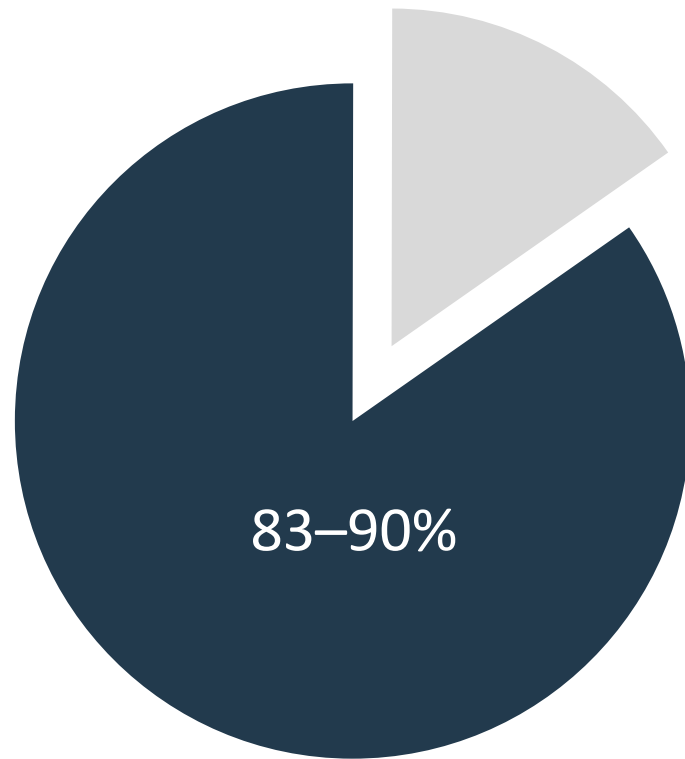
Adapted from Figure 4-4, Assessment B Report

Enrollees residing more than 40 miles driving distance from a VA facility also have poor access to non-VA specialty care

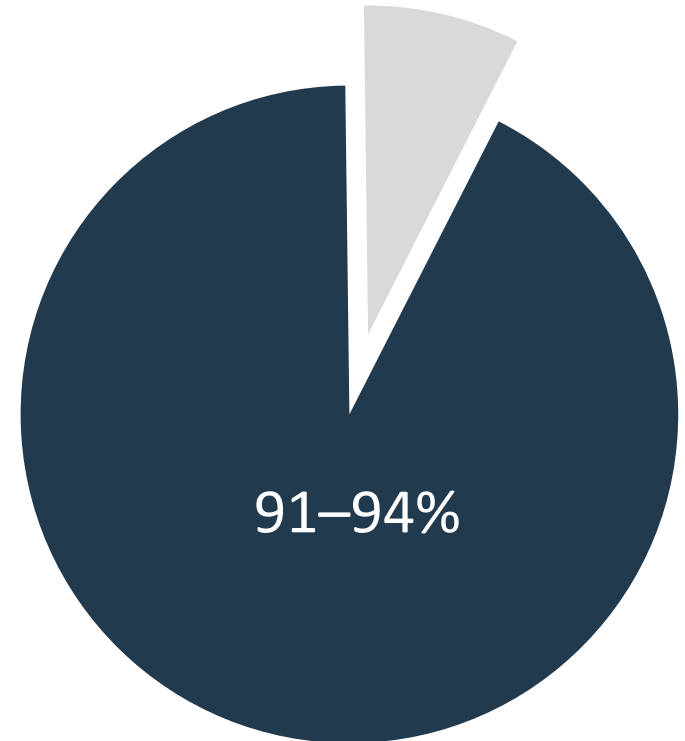


Adapted from Figure 4-10, Assessment B Report

Most VA patients get appointments within two weeks of the preferred date



New patients

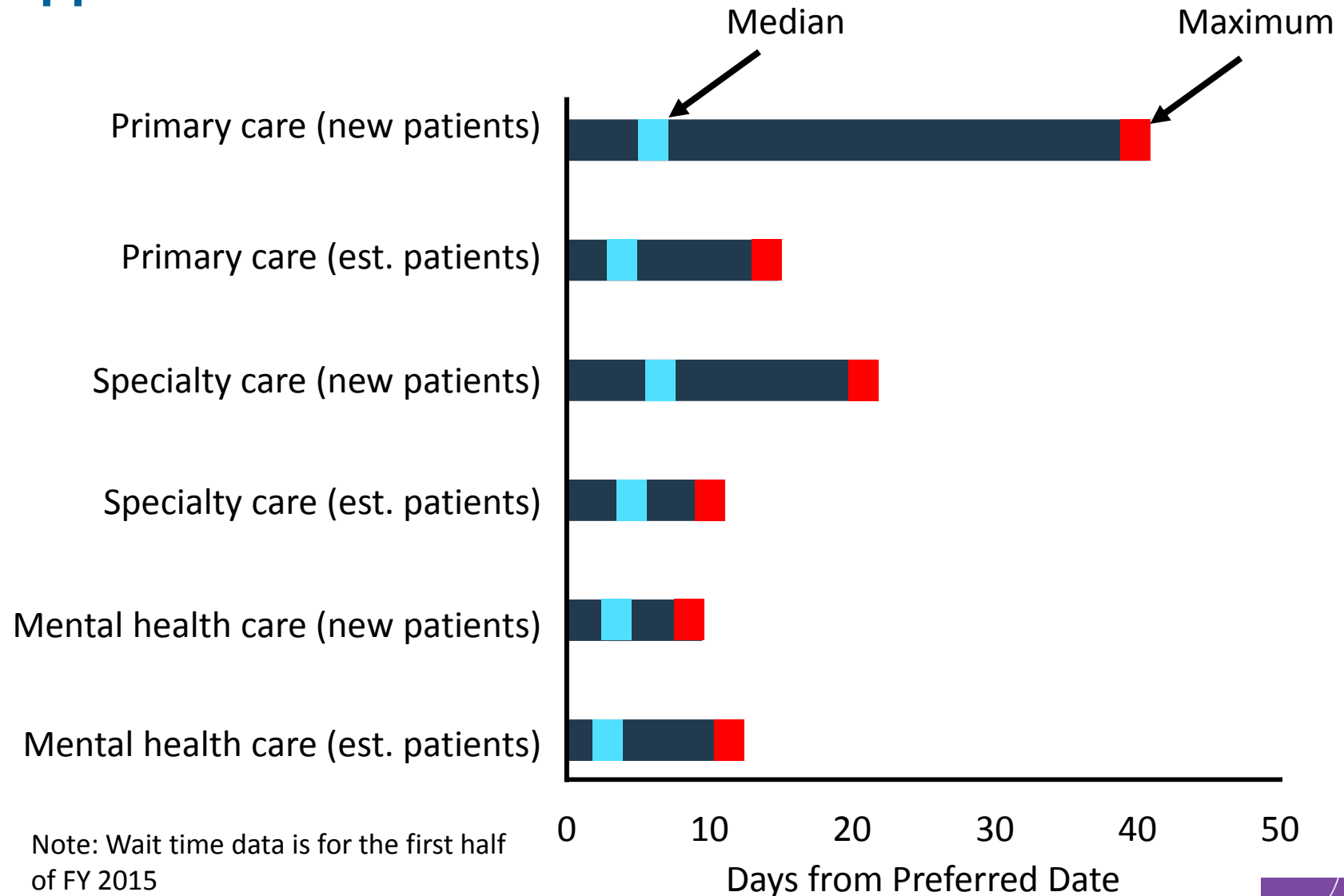


Established patients

Note: Wait time data is for the first half of FY 2015

Adapted from Figure 4-14, Assessment B Report

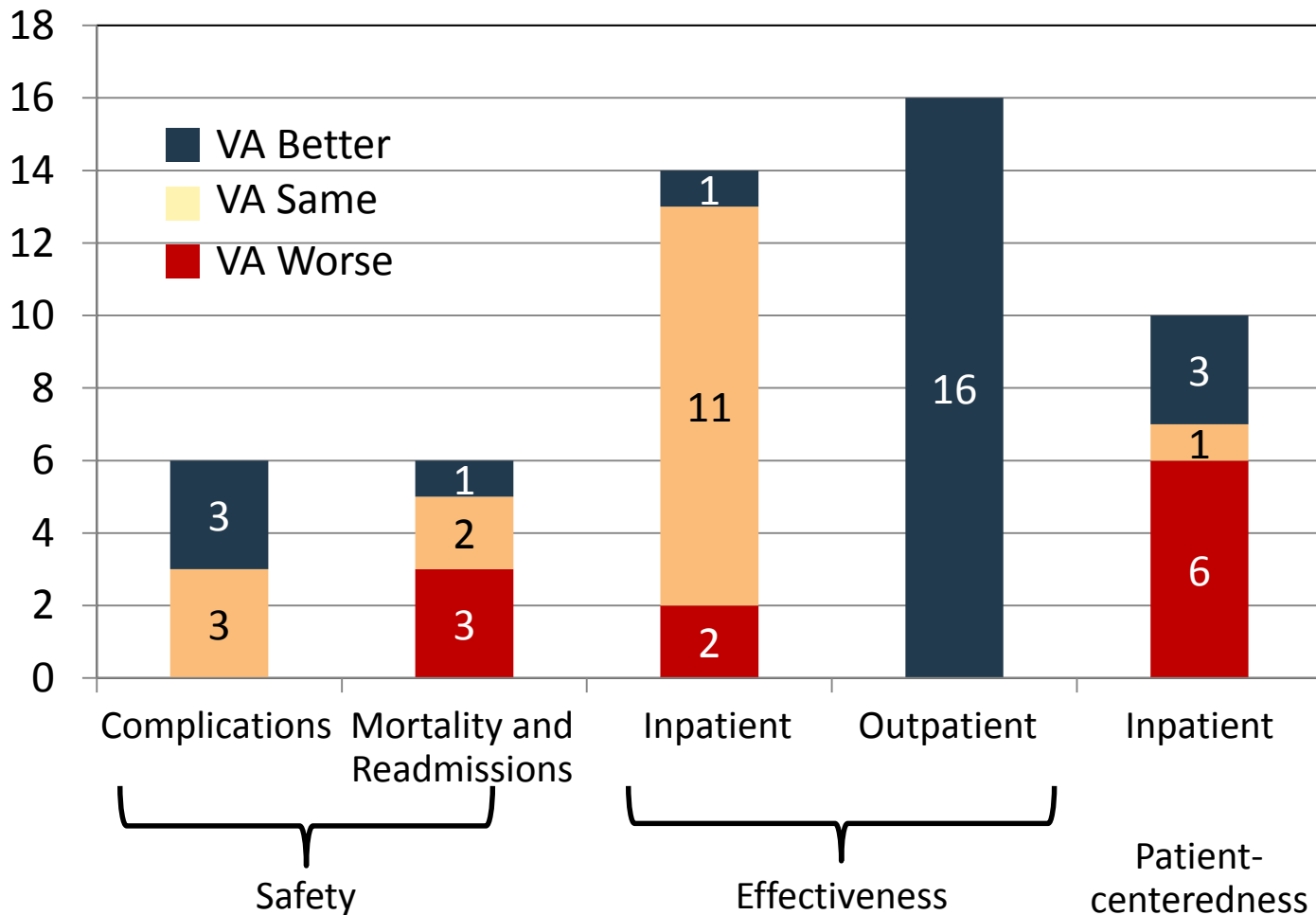
Some facilities have much longer waits for appointments



Adapted from Figure 4-16, Assessment B Report

Compared to other health systems, VA quality on many measures is good

Number of measures



Adapted from Figure 5-2, Assessment B Report

VA facilities' performance on quality varies widely

Eye Exams in Patients with Diabetes in Outpatient Setting:
Number of VA Facilities by Measure Rate, FY 2014

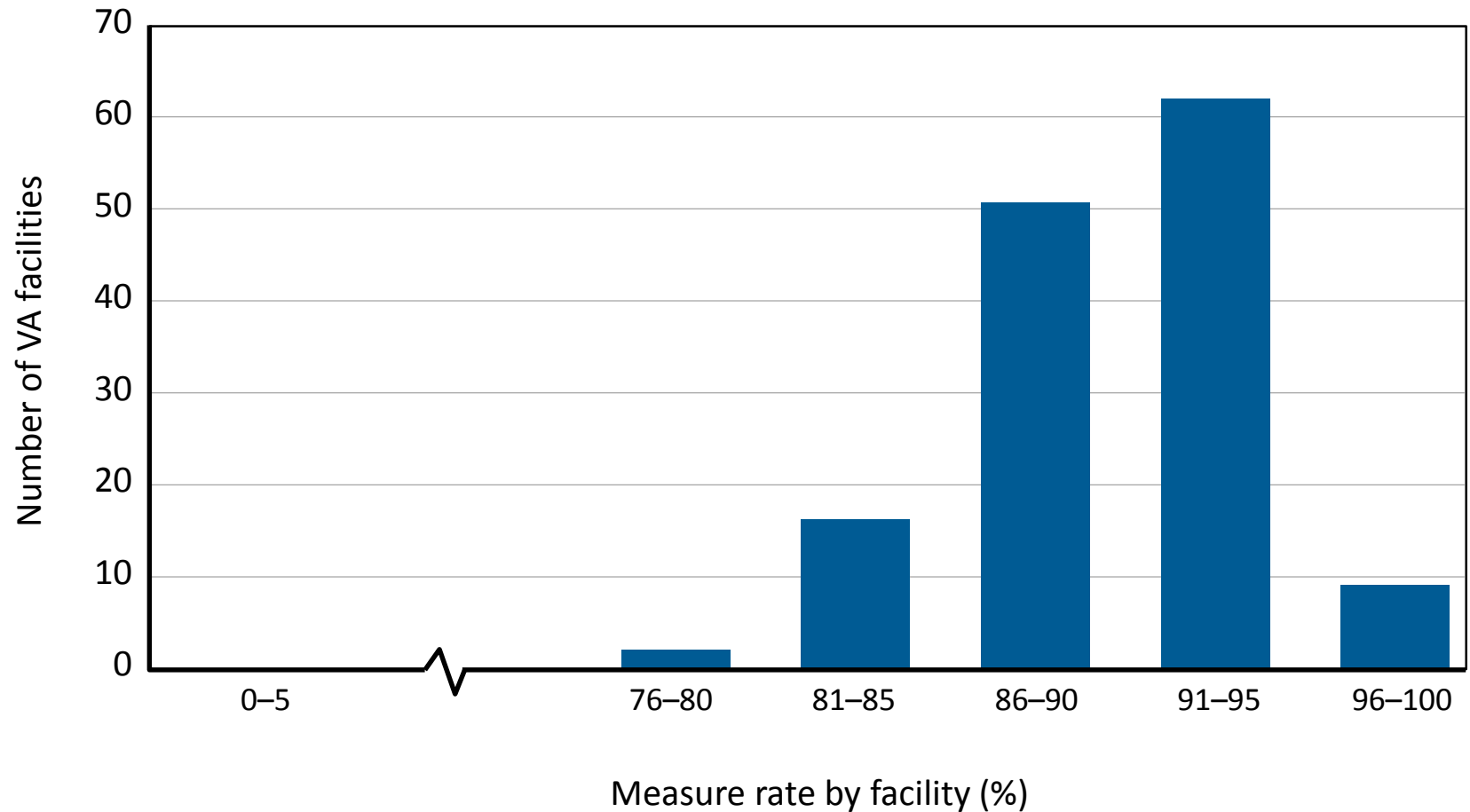


Figure 5-15, Assessment B Report

Demand for VA services will grow faster than supply

Projected Growth in Demand and Supply for VA Health Care Services, from FY 2015 to FY 2019

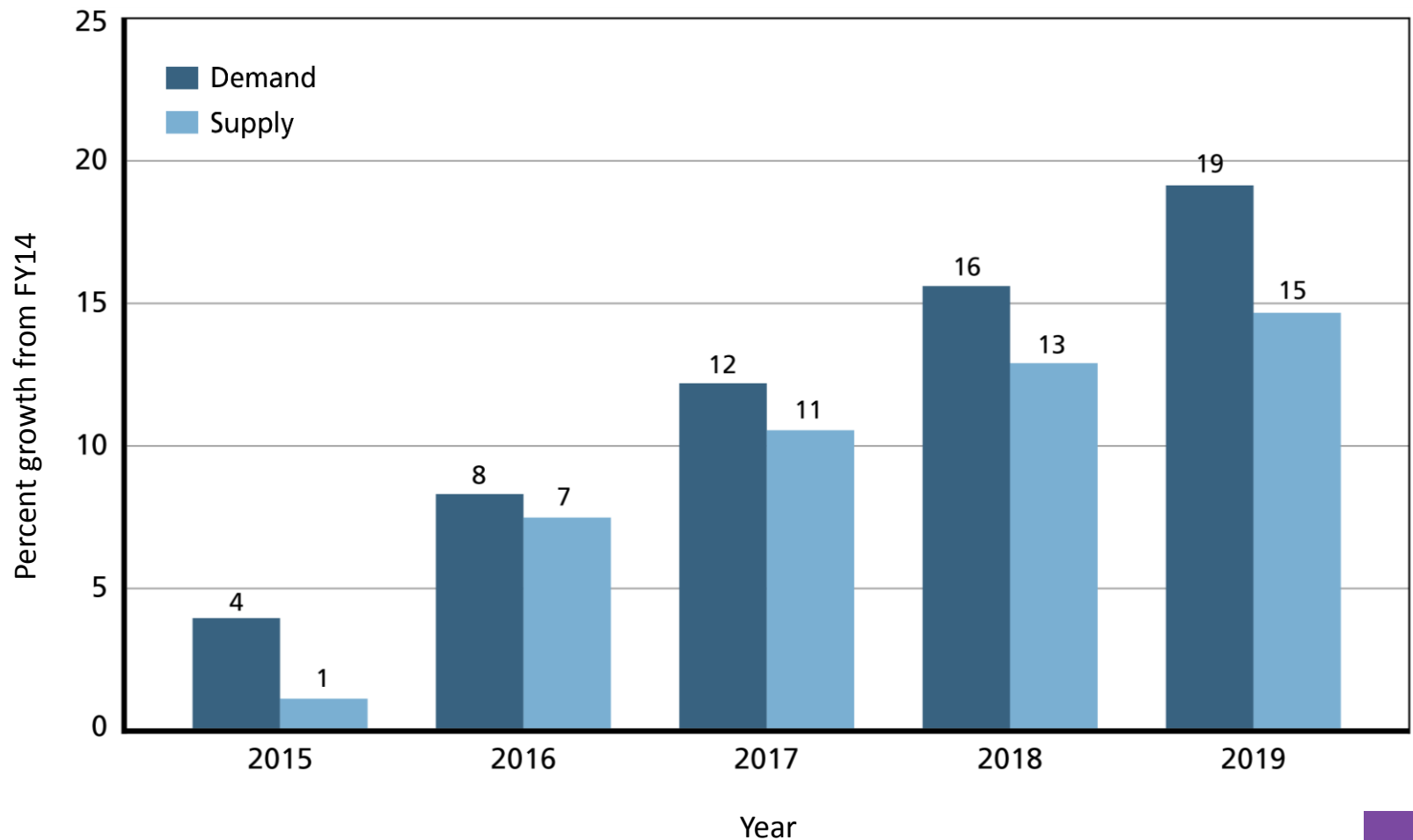
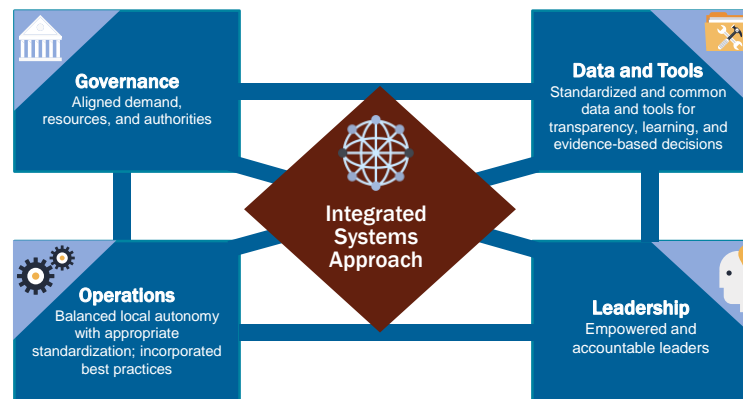


Figure 6-2, Assessment B Report

Assessment B Recommendations

- Use a systematic, continuous performance improvement process to improve access to care
- Systematically identify opportunities to improve access to high-quality care through use of purchased care
- Consider alternative standards of timely access to care
- Develop and implement more sensitive standards of geographic access to care
- Take significant steps to improve access to VA care, such as formalizing full nursing practice authority, increasing physician hiring, and increasing the use of virtual care.





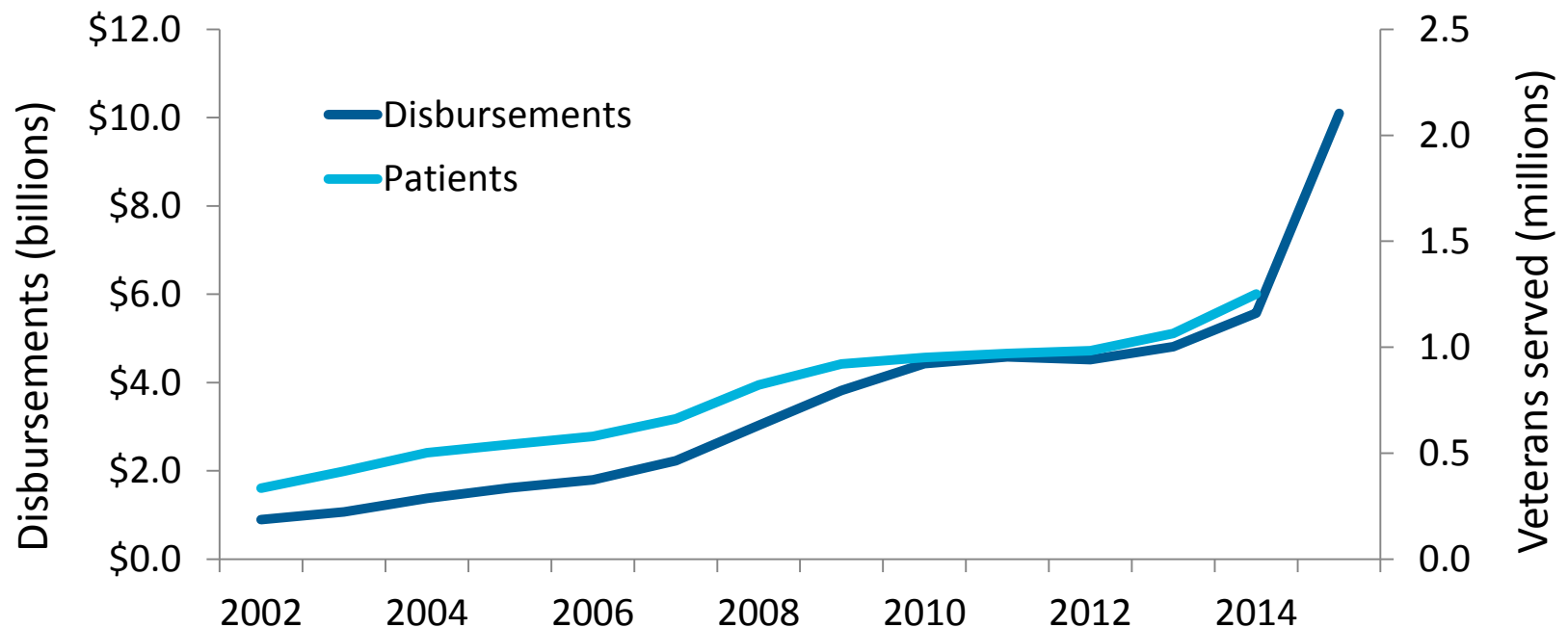
Assessment C: Care Authorities

Conduct an assessment of the “authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Department facilities, including whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care.

Assessment C: Care Authorities

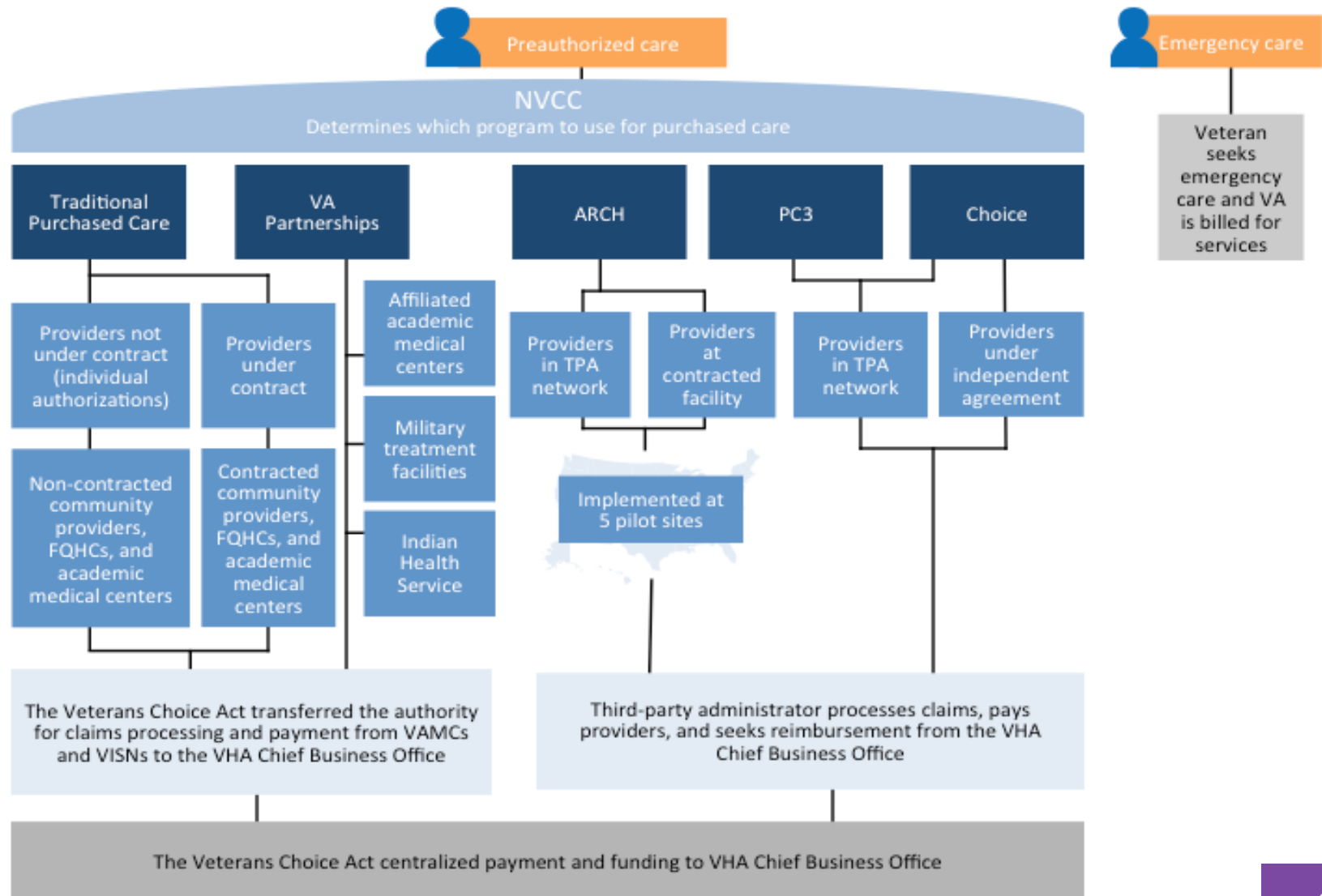
Summary Findings

- Role of purchased care has grown (\$5.6B in FY14)
- VA has multiple and confusing authorities for purchasing care, including episodes
- No clear make-buy strategy for delivering care



What role should VA purchased care play going forward?

VA has multiple programs for purchasing care from community providers



FQHC: federally qualified health center
NVCC: Non-VA Care Coordination

ARCH: Access Received Closer to Home
PC3: Patient-Centered Community Care

TPA: third-party administrator



Authorities to purchase care are dispersed throughout Title 38

Traditional Program 38 USC 1703

- VA *may* purchase care when not capable of furnishing medically necessary care

Emergency Care 38 USC 1725 & 1728

- VA *may* compensate eligible Veterans for outside emergency services in specified circumstances

Choice Card VACAA § 101

- VA *must* purchase care when wait time and/or distance criteria are met

Assessment C report includes detailed description of legal authorities

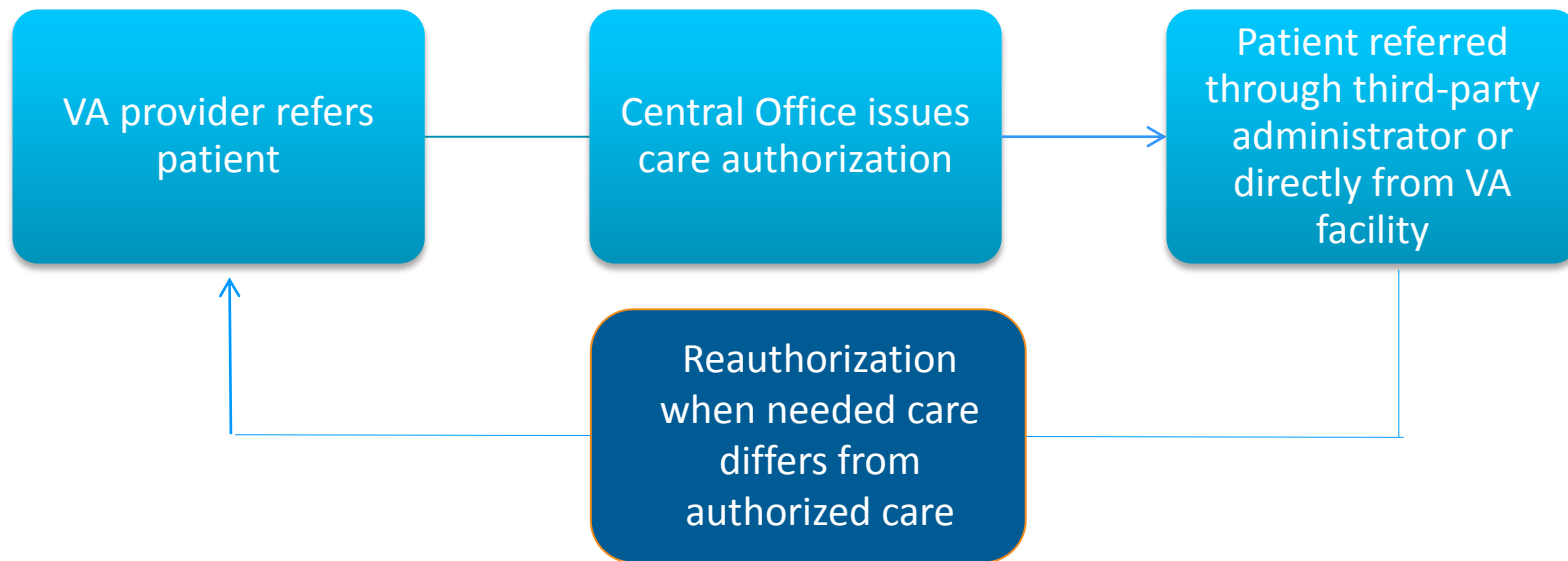


Authorities contain some inconsistent requirements, leading to confusion among Veterans, VHA staff, and providers

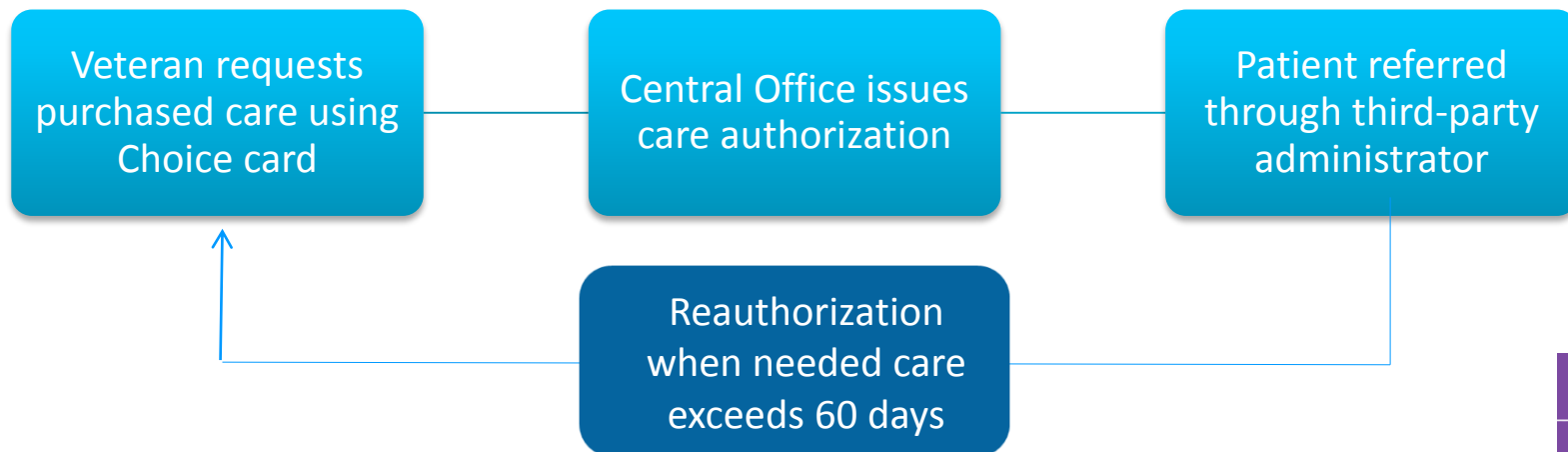
	Traditional Program	Choice Card
Eligibility	Enrolled Veteran needing care for <ul style="list-style-type: none">• service-connected condition• any condition <i>if</i><ul style="list-style-type: none">- First seen by VA provider- Non-VHA care required to complete treatment	Previously enrolled or combat Veteran <ul style="list-style-type: none">• Over 40 miles from VA facility• Cannot get care within 30 days VA determines medical necessity
Eligible providers	Any provider with VHA contract or individual authorization	Medicare-eligible providers with VHA contract
Payment rate	None specified	Medicare rates
Veteran choice	None specified	Veteran may choose any qualified provider

Authorization rules can interrupt episode of care

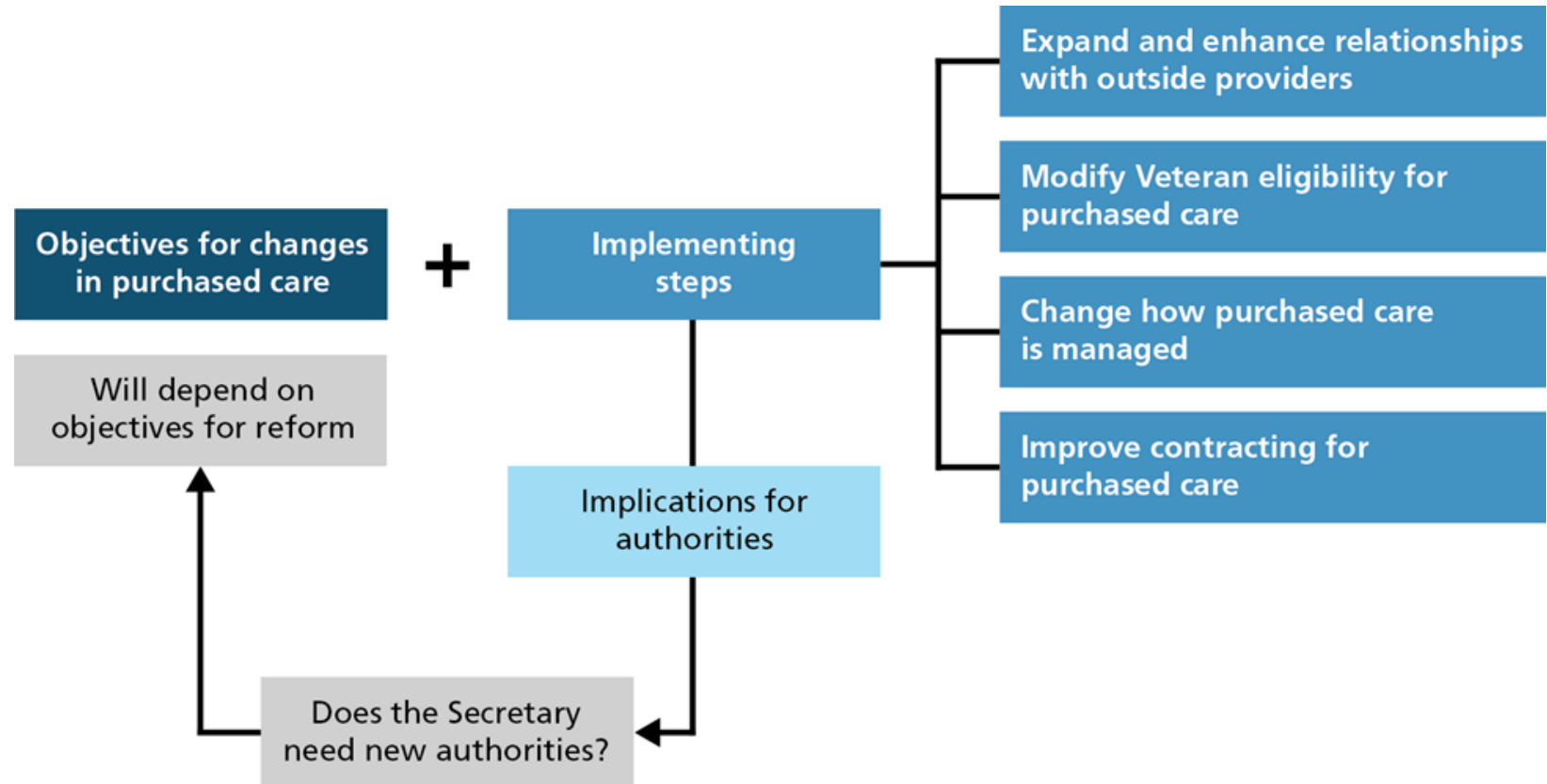
Traditional Program



Choice Card

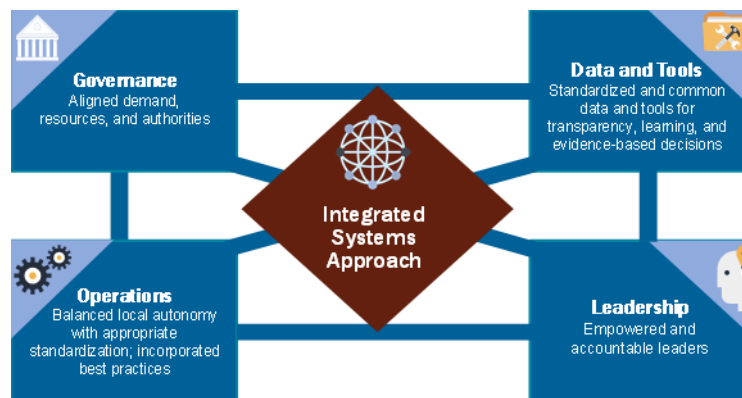


Different objectives and strategy for purchased care would imply different revisions to the authorities



Assessment C Recommendations

- **Define a strategy for purchased care**
- Simplify the purchased care program and establish clear goals and objective benchmarks for success
- Address cost and quality control more explicitly and systematically
- Develop a stronger management structure for purchased care
- Collect better data to accurately estimate demand for and measure quality, access, and costs of purchased care
- Evaluate third-party contractors administering PC3 and Choice





Assessment I: Business Processes

Conduct an assessment of the business processes of the Veterans Health Administration, including processes relating to furnishing non-Department health care, insurance identification, third-party revenue collection, and vendor reimbursement, including mechanisms to:

- i. Avoid the payment of penalties to vendors.**
- ii. Increase the collection of amounts owed to the Department for hospital care, medical services, or other health care provided by the Department for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate.**
- iii. Increase the collection of any other amounts owed to the Department with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate.**
- iv. Increase the accuracy and timeliness of Department payments to vendors and providers.**



Assessment I: Summary of Findings

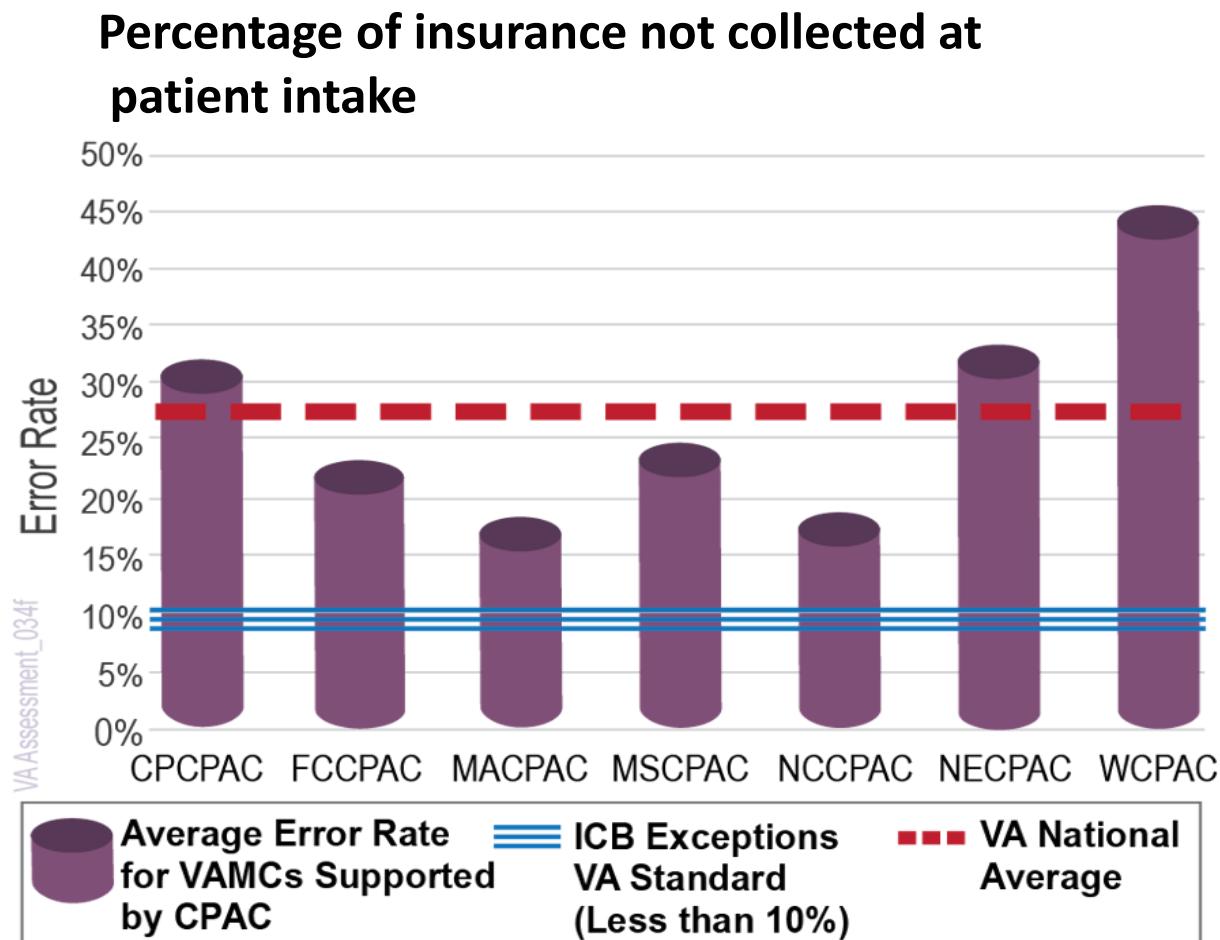
Revenue

- 1 Insurance information not captured timely, requiring costly, retroactive patient accounting processes and outside contractors (25.9% of patient check-ins resulted in an error).
- 2 Approximately 55%, or \$580.1m, of denials received related to Patient Intake processes in revenue cycle.
- 3 Patient accounting system requires significant manual intervention, causing errors and delays.

Non-VA Care

- 4 Inconsistent use of available purchased care options – Non-VA Care, PC3, Choice Card Program.
- 5 Only 29% of Non-VA claims submitted to VHA via Electronic Data Interchange (EDI). No claims are automatically adjudicated.
- 6 VHA is not Paying Non-VA Care Claims Timely and Accurately.
- 7 Interest penalties are low compared to industry benchmarks, however, VHA risks increased penalties pending a VA OGC review.

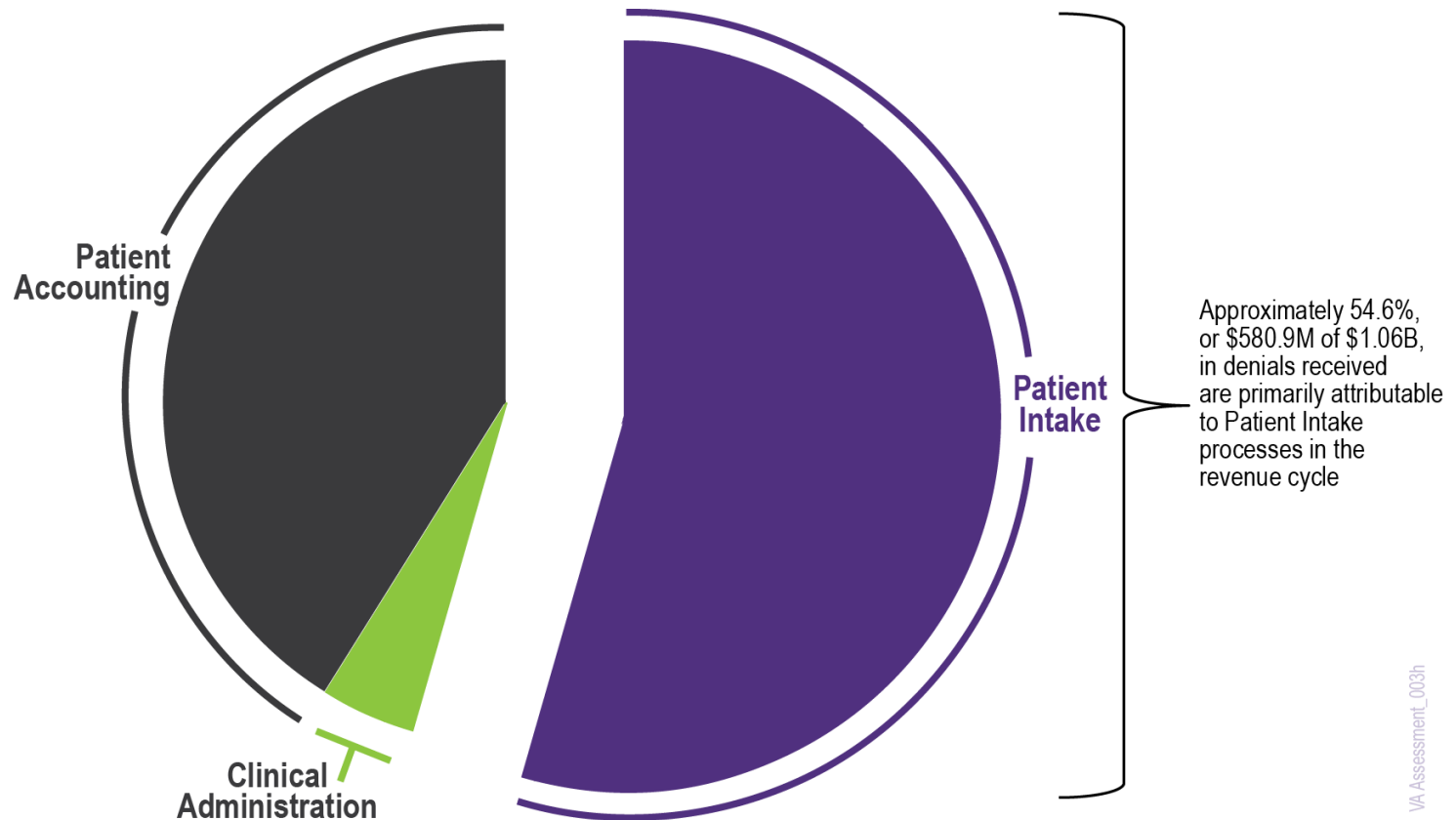
1 Insurance information is not captured timely



Source: VAMC Insurance Capture Error Rate Data Call Results. ICB exception rate data for Calendar Year 2014 was obtained via a VAMC-wide data call. There were 123 VAMC respondents that provided their error rate. An average error rate for VAMCs support by CPAC was calculated at the CPAC level.

Report Reference: Section 6.3.3 Cultural Barriers (Page 58)

2 Approximately 55% of denials received related to Patient Intake



Source: Author rendition based on National Initial Denials CY2014 data provided by CBO
Report Reference: Section 6.3.5 Denials (Page 66)



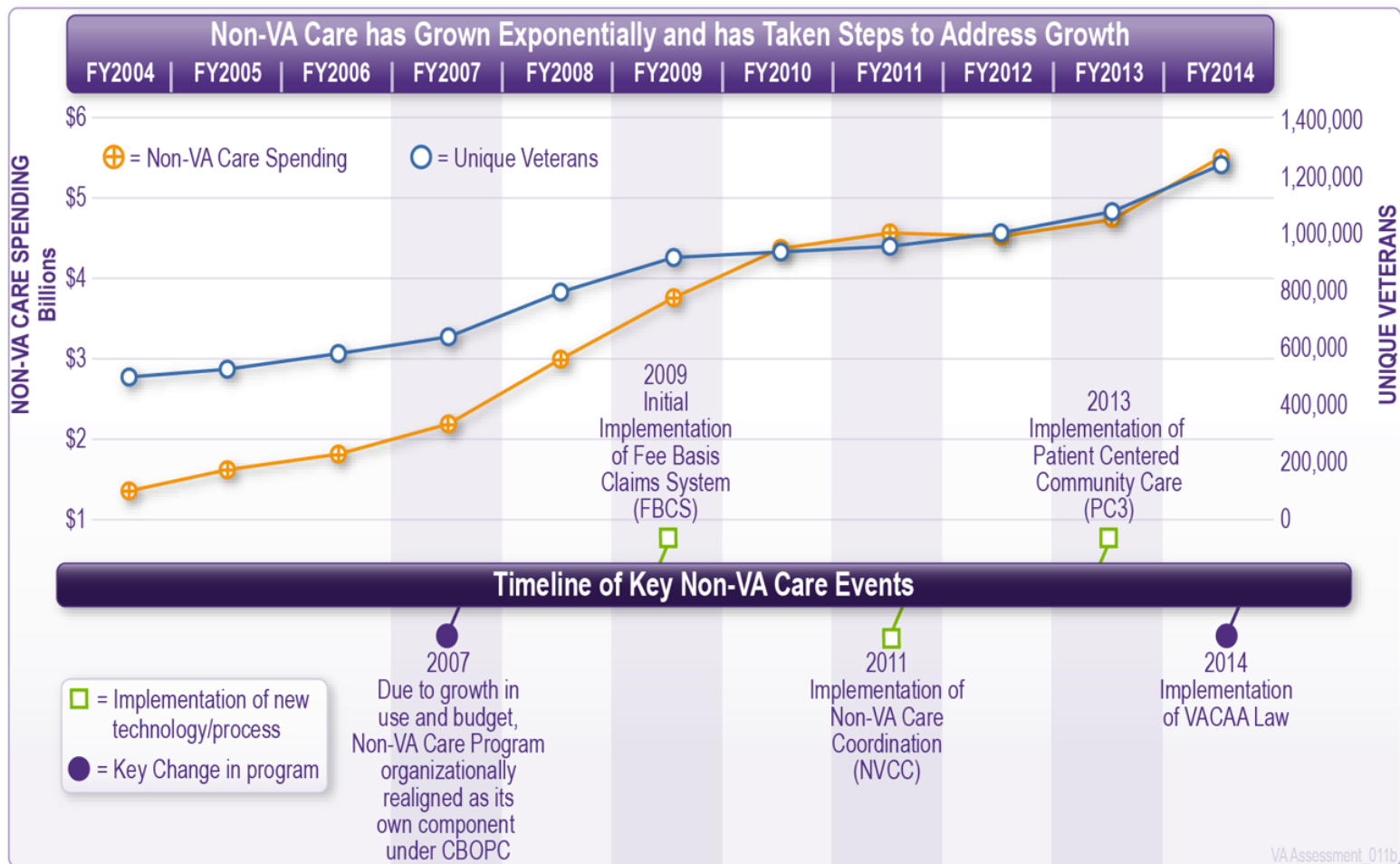
3 Patient accounting system requires manual intervention

VHA's percent of manual review of claims is high compared to the industry standard of 10-20 percent. Private sector patient accounting systems require less manual review.

- Two primary drivers necessitate the manual review of VHA claims to third-party payers:
 - VHA has to test for service connectedness.
 - It is common for a VHA patient to have multiple services in one day, which adds to the complexity of the bill.
- Biller productivity, claims accuracy, and collections could be improved with an improved billing system.

Source: Qualitative interviews & review of CPAC organization charts
Report Reference: Section 8.2.4 VHA Billing (Page 129)

Growth of Non-VA Care

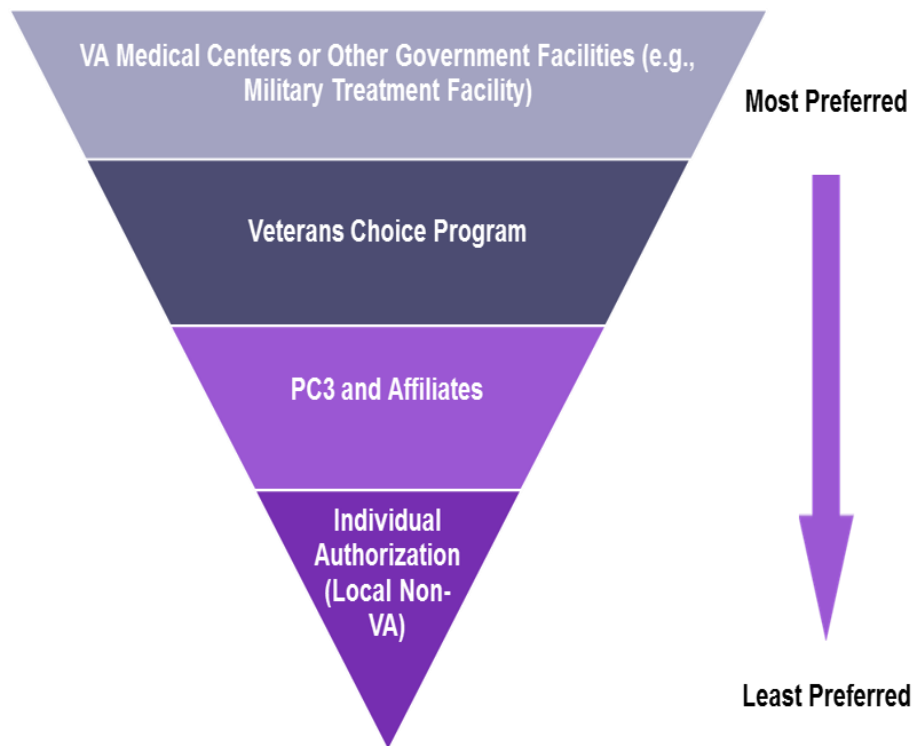


Source: Paid and Timeliness FY12-FY14 Data

Report Reference: Section 7.1.2 Non-VA Care Current State (Page 82)

4 Inconsistent use of available purchased care options

There is an inconsistent use of available purchased care options (i.e., Non-VA Care, PC3, and the Choice Card Program) and the differences and complexity within these programs create challenges for VHA and Non-VA providers.



Source: Grant Thornton's rendition of VHA's designated sequence order for care based on qualitative interview

Report Reference: Section 7.1.2 Non-VA Care Current State (Page 86)



5 Only 29% of Non-VA claims submitted to VHA via EDI

- For FY 2014, only 29% of claims submitted via Electronic Data Interchange (EDI); benchmark for commercial claims is 94% submitted electronically.*
- VHA's claim adjudication system lacks the functionality to adjudicate claims automatically. Benchmark for commercial claims is 79% auto-adjudicated.**

Source: Paid and Timeliness FY12-FY14 Data and AHIP Center for Policy and Research

*Report Reference: Section 8.3.3 Electronic Claims (Page 134)

**Report Reference: Section 7.5.1 Staffing (Page 111)

6 VHA is not Paying Non-VA Care Claims Timely and Accurately

Payment Timeliness*

FY	VHA Performance Interest Percentage ¹⁸⁶	VHA Performance Standard	Commercial or Other Payer Benchmark ¹⁸⁷
2012	.009%	.03%	0.8%
2013	.004%	.03%	0.8%
2014	.005%	.03%	0.8%
Note: VA's Office of General Counsel is reviewing whether VAMC business practices where rates for individual authorizations <u>are not negotiated</u> are considered a contract subject to interest penalties. If VHA is found liable, it would be subject to pay retrospective interest penalties to Non-VA providers operating under individual authorizations and subject to greater interest penalties in the future.			

Payment Accuracy**

FY	VHA Payment Accuracy	VHA Performance Standard	Commercial or Other Payer Benchmark
2012	88.0%	98.5%	97%
2013	90.35%	98.5%	97%
2014	90.76%	98.5%	97%

*Source: VA Informatics Denial data, VHA Directive 2010-005, and UnitedHealthcare Benchmark Report Reference: Section 7.3.1 Timeliness (Page 93)

**Source: IPERA 2012-2014 Reports and UnitedHealthcare Benchmark Report Reference: Section 7.3.2 Accuracy (Page 94)



7 Interest penalties are low compared to industry benchmarks

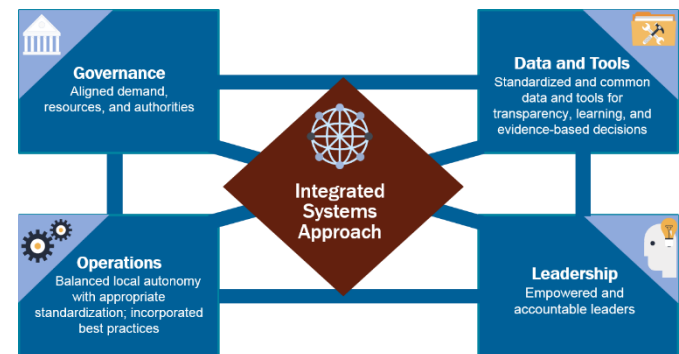
- VHA's interest payments in 2014, about ½ of 1 percent on the \$5.6B of paid claims.
- VA's Office of General Counsel (OGC) is reviewing to determine if agreements are subject to interest penalties. VHA may face a significant increase in their interest penalty payments.

*Source: Paid and Timeliness FY12-FY14 Data

*Report Reference: Section 7.4.1 Interest (Page 109)

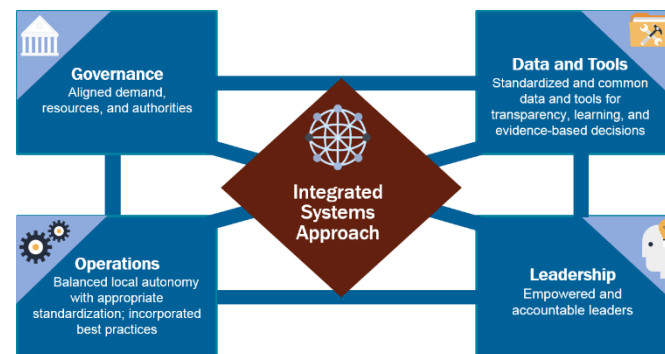
Summary of Assessment I Recommendations

- VHA should develop a long-term comprehensive plan for provision of and payment for non-VA health care services.
- Establish a formal governance model that allows CBO and VISN leadership to converge, aligning interests and accountability.
- Align performance measures to those used by industry, giving VHA leadership meaningful comparisons of performance to the private sector.



Summary of Assessment I Recommendations

- Simplify the rules, policies, and regulations governing revenue, Non-VA Care, eligibility, priority groups, and service connections.
- Standardize policies and procedures for execution of Non-VA Care, particularly the Choice Act, and communicate policies and procedures to Veterans, VHA staff, and Non-VA providers.
- Employ industry standard automated solutions to bill and pay claims.





Assessment E: Scheduling workflow

The **workflow process at each medical facility of the Department for scheduling appointments** for veterans to receive hospital care, medical services, or other health care from the Department.



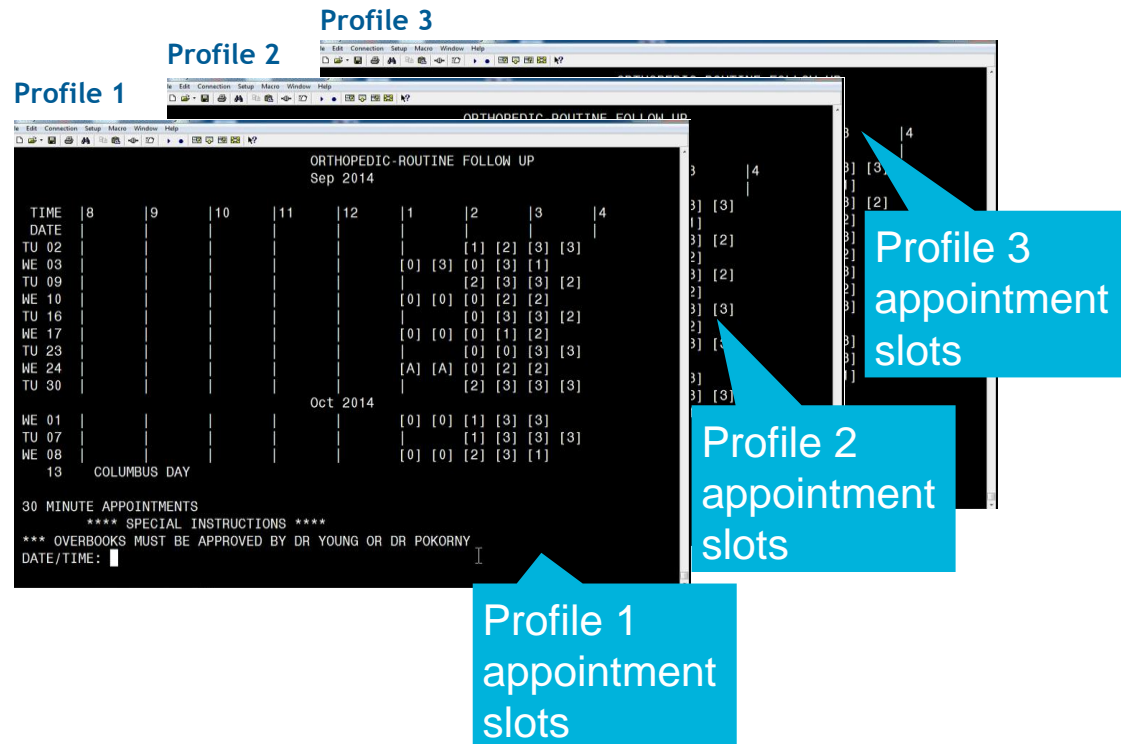
Overview of assessment E findings

Significant opportunity to improve appointment supply and utilization within current provider capacity based on following findings:

- System limitations prevent accurate visibility into available appointment supply, inhibiting ability to understand, plan for, and meet Veteran needs
- There is inconsistent use of standard industry practices related to schedule setup, standard appointment lengths, reminders, etc.
- Policies (such as patient desired date and electronic wait lists) add administrative burden with unclear benefit
- There are gaps in training, with >90% of schedulers noting need for more—in part due to complexity of VHA processes
- Call centers, where they participate in scheduling, are generally subscale and variably managed

System limitations can result in overlapping schedules that reduce visibility into total appointment supply and utilization

Example view of clinic profiles for one provider



Can result in over-counting of appointment supply and under-estimates of overall utilization

Within same time period (e.g., 12 p.m.), appointment slots for one provider can be spread across multiple profiles due to requirement to have profiles for different services, locations, etc.

Manual analysis is required to understand time made available for scheduling; not all schedules match expected clinical FTE

Actual physician profiles from same clinic, both 1.0 clinical FTE

Mental health clinic, week of Sept 8-12, 2014

Provider	Weekly appointment slots set in schedule	Portion of 1.0 CFTE time represented by those slots Percent
Physician X	56	93
Physician Y	28	47

- Provider Y starts no earlier than 9:30 am each day
- Provider Y does not work Monday afternoons
- Provider Y's Thursday schedule only includes 1.5 hours in clinic

Assumes 35 hours available for scheduling patient visits

SOURCE: Site visit VAMC

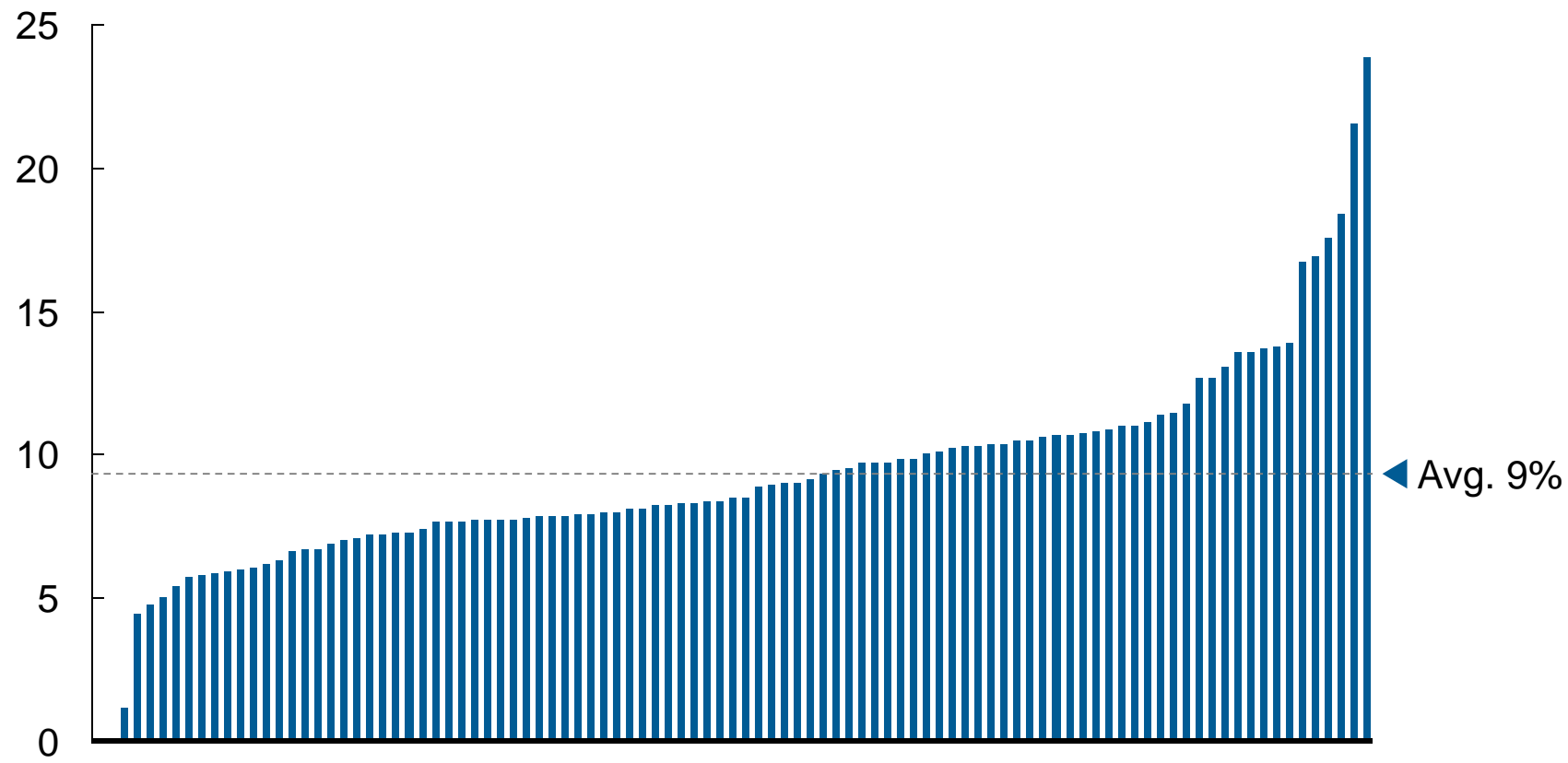
NOTE: Figure 5-3 in assessment report



Cancellations driven by the clinic can also reduce appointment supply or, at minimum, result in scheduling rework

Appointment cancellation by clinic rate for select stop codes at site visit facilities

Percent, N=99 clinics, Feb - July 2014



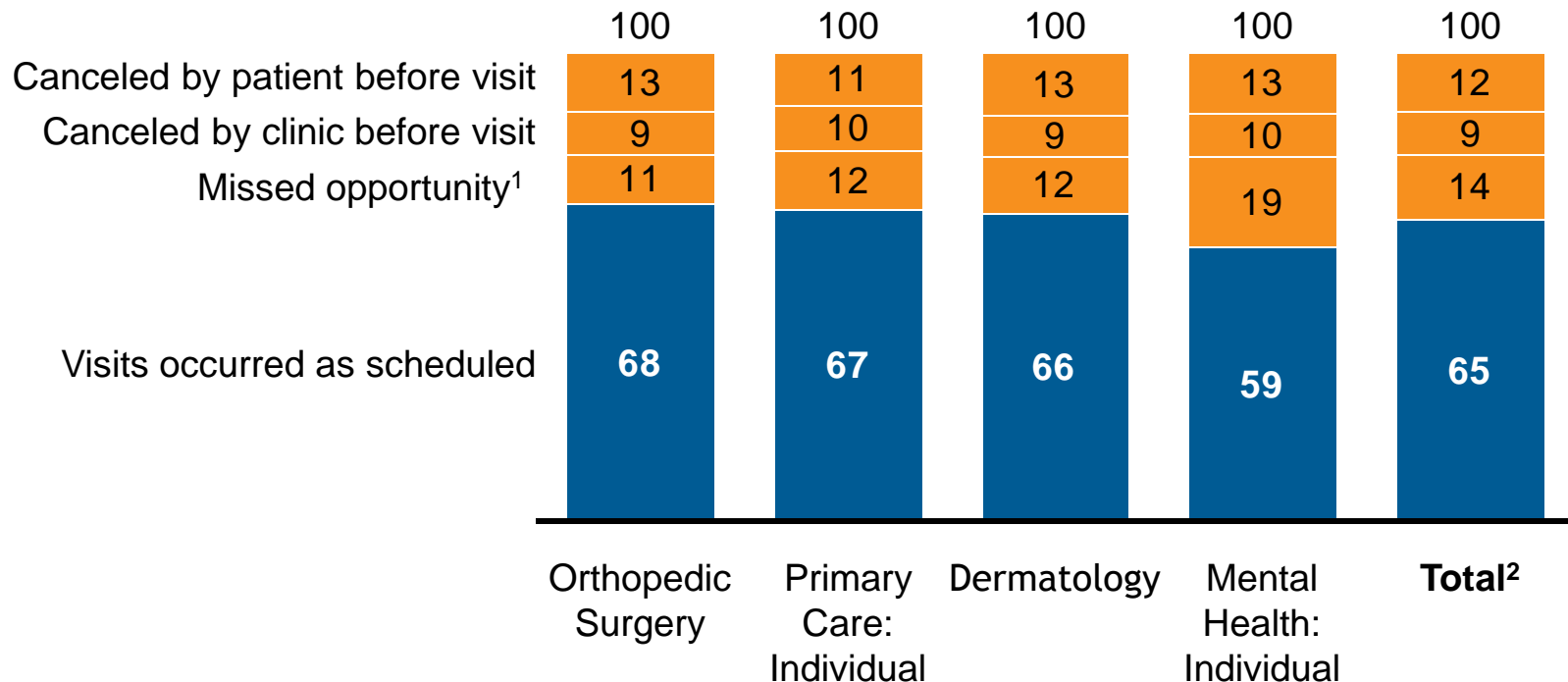
SOURCE: Clinic Assess Index
NOTE: Figure 5-7 in assessment report

As a result of cancellations by clinic and missed opportunities (no shows), many appointments are not completed as originally scheduled

Clinic appointments completed as originally scheduled for select stop codes

Percent of appointments booked, N=25 VAMCs

Original appointment did not result in patient visit



¹ No-show or canceled by clinic / patient after appointment time such that provider time went unused

² Total of these four stop codes

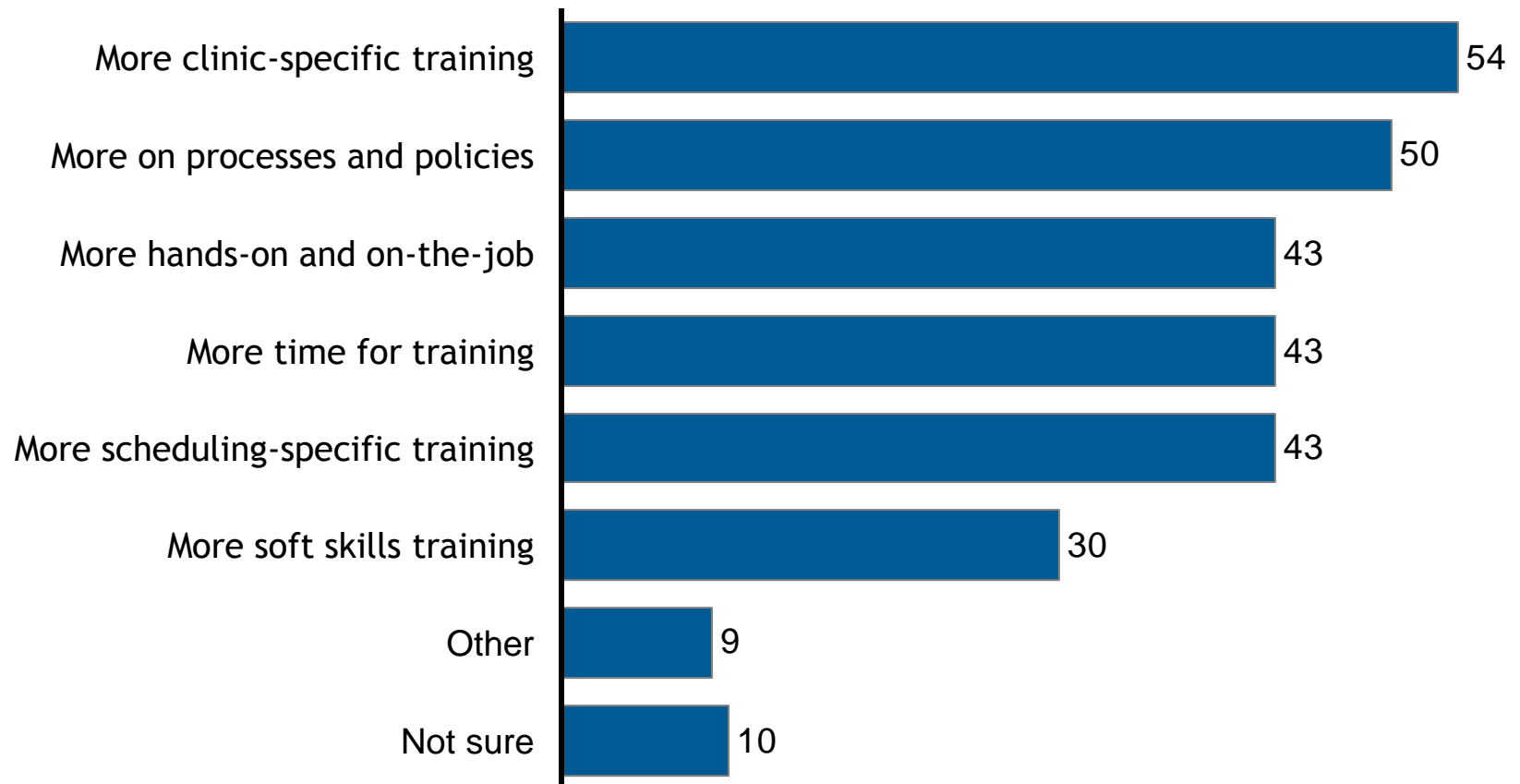
SOURCE: Clinic Assess Index

NOTE: Figure 6-4 in assessment report

Schedulers report that clinic-specific and national policies increase scheduling complexity, potentially without improving appointment utilization

How would you improve training of schedulers?

Percent, N=825 scheduler responses from 97 VAMCs and 128 CBOCs



SOURCE: 2015 VHA Choice Act Assessment E Employee Survey; Scheduler focus groups

NOTE: Figure 8-1 in assessment report

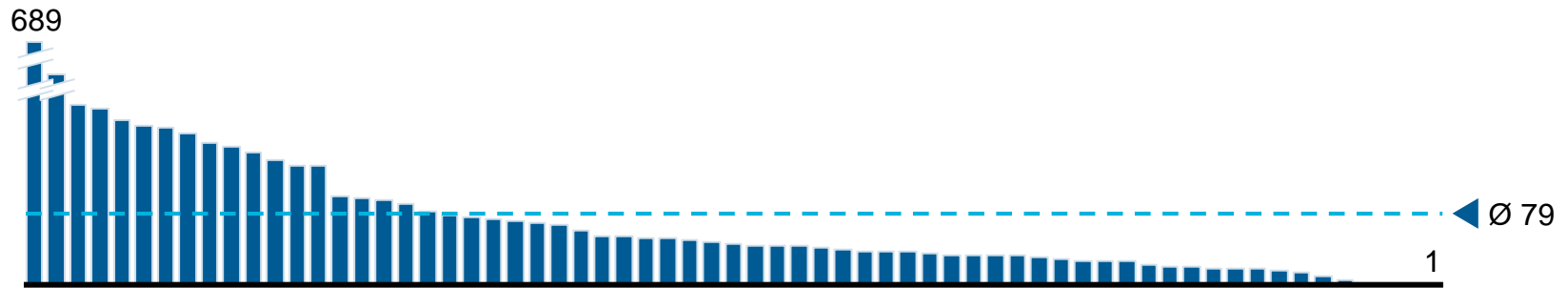
Variable levels of service for scheduling, even within call centers, can also impact patient experience and access

Self-reported average speed of answer and abandonment rate for scheduling call centers

N=65

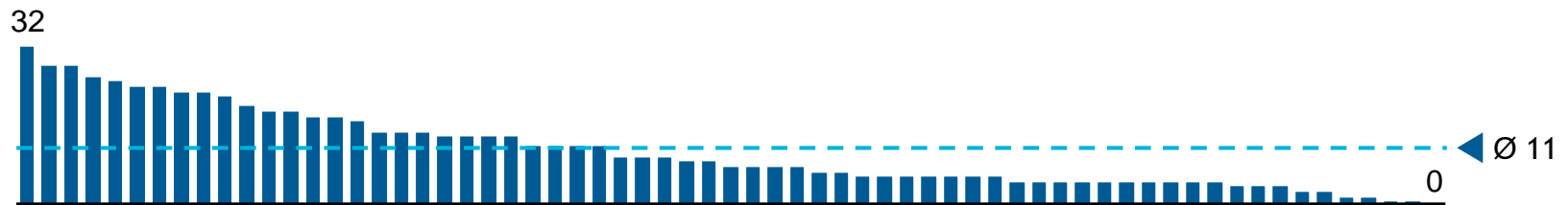
Average speed of response/answer for FY 2014¹

Seconds



Average abandonment rate for FY 2014¹

Percent



Average VHA scheduling call center size of 12 agents versus private sector provider average of 28

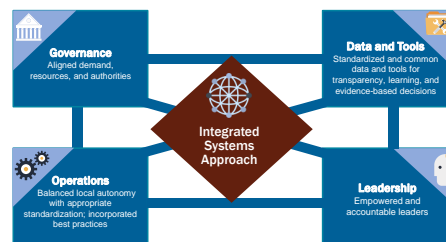
1 Based on 65 responses that indicated there was a call center and reported speed of response greater than 0

SOURCE: Choice Act Assessment E Data Call; Belfiore, et al (2015)

NOTE: Figure 9-5 in assessment report

Assessment E recommendations

- **Address system limitations to provide visibility into appointment supply**
 - One consolidated schedule for each provider
 - Ability to accurately aggregate appointment supply data
- **Codify proven scheduling practices and empower clinics to use them**
 - Dissemination of tools and best practices from within VHA
 - Addressing the lack of clinic management resourcing and scheduler vacancies, and ensuring that providers have an understanding of necessity
- **Streamline scheduling policy implementation with tools and technology**
 - Automation of manual process (e.g., wait time measurement)
- **Ensure that clinic manager training program is well scoped and resourced** to manage provider availability (schedule set-up, design, utilization) and scheduling
- ***Design larger scheduling call centers that offer expanded, consistent services*** to access the benefits of scale
- **Improve scheduler training, e.g., by increasing experiential training** with scheduling system improvement and policy streamlining as enablers





Assessment F: Clinical Workflow (Inpatient)

Conduct an assessment of the “organization, workflow processes, and tools used by the Department to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.”



Assessment F – Inpatient Clinical Workflow



Summary Findings



- Ineffective data collection and management, driving lack of transparency
- Mismatching of VHA resources to Veteran needs (in part due to weak data)
- Isolated pockets of best practices

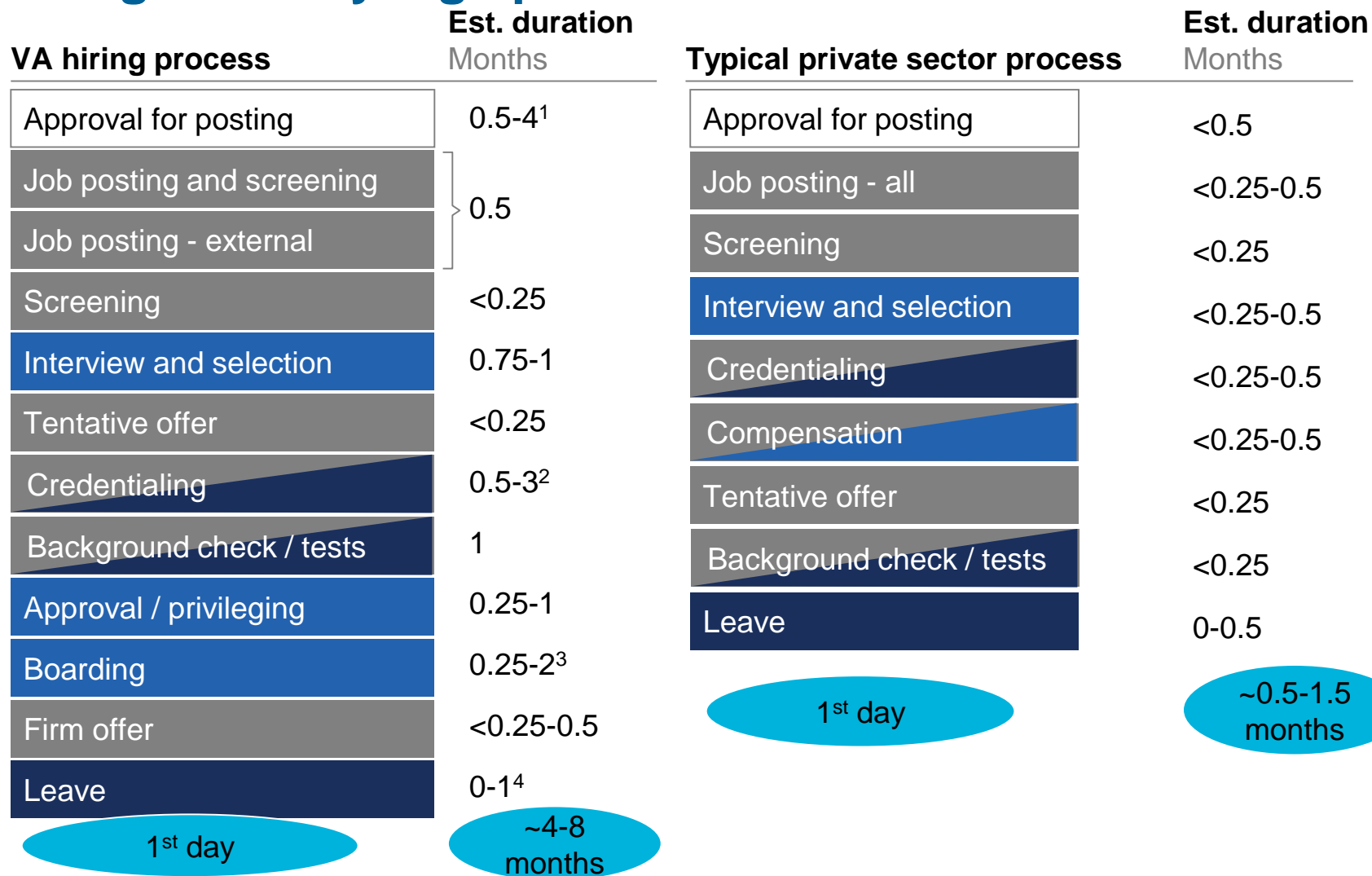
Specifically:

- 1 Clinical staffing: Limited staffing level guidance, long hiring times leading to gaps
- 2 Access to care: Inaccurate understanding of patient demand and available capacity, as well as inconsistent admission and bed management practices
- 3 Length of stay: Longer than benchmarks, driven by challenges in post-discharge placement and inefficiencies (e.g., limited weekend consults)
- 4 Patient experience: Many best-practice innovations, but isolated deployment
- 5 Doc. & coding: Inconsistent focus on documentation, but strong coding accuracy

1 Clinical staffing: VHA RN hiring timeline significantly lags private sector

 VAMC leadership
 HR / admin

 VAMC clinical staff
 Candidate



1 Length depends on how frequently the committee meets, and whether a request is returned for additional clarification, requiring resubmission

2 Longer than private sector because requirements are typically greater; length varies depending on how easily HR is able to contact references and whether candidates submits all information in a timely manner, 3 Length depends on how often the peer Professional Standards Review Board meets

4 Length can exceed private sector for 2 reasons: (1) onboarding dates are typically set for large cohorts and inflexible, resulting in individual candidates spending several weeks waiting for their start date and (2) length and uncertainty of VHA hiring timeline often means candidates do not put in their leave until their firm offer, delaying their onboarding

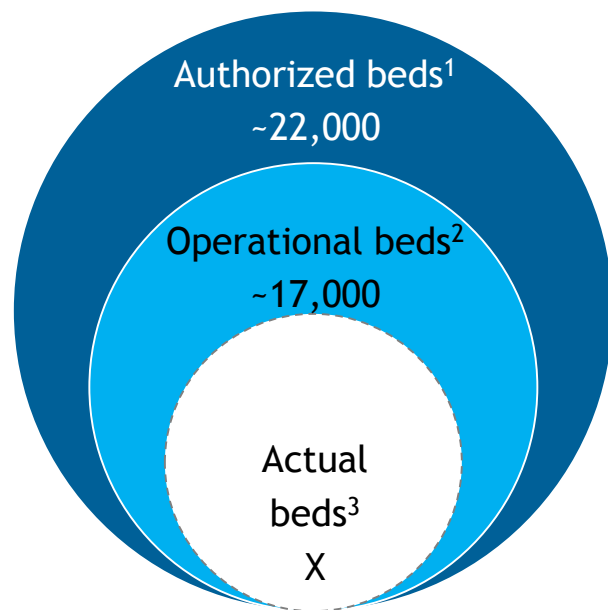
NOTE: Figure 5-2 in Assessment F report

2 Access to care: Operational bed numbers, at the national level, do not reflect actual bed capacity at the facilities

■ Data reported in National Bed Control Database ■ Data reported by the VAMCs □ Data unknown

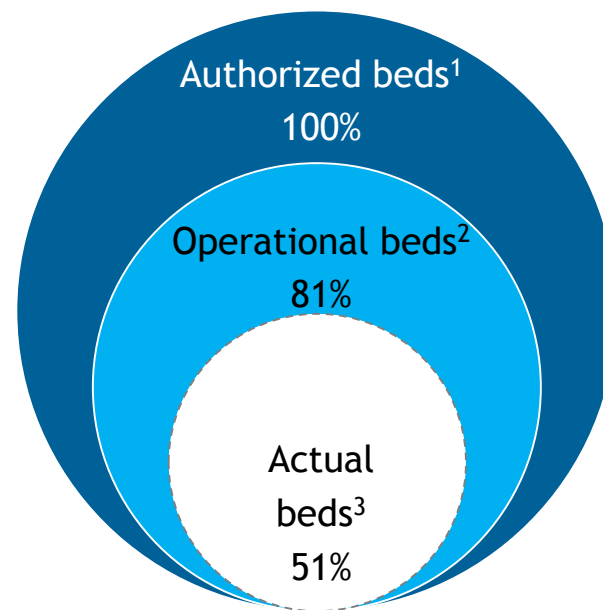
National bed data

Number of national inpatient acute care beds (med., surg., psych.)



Case study of a single VAMC

Percent



38% of VAMCs reported closing beds (e.g., due to staffing limitations and/or construction) without going through the national bed letter process; as a result it is unclear the actual number of available beds across the system

1 Total authorized acute beds (e.g., potential capacity of the system as reported to NBCD)

2 Total operating beds (e.g., staffed beds reported to NBCD)

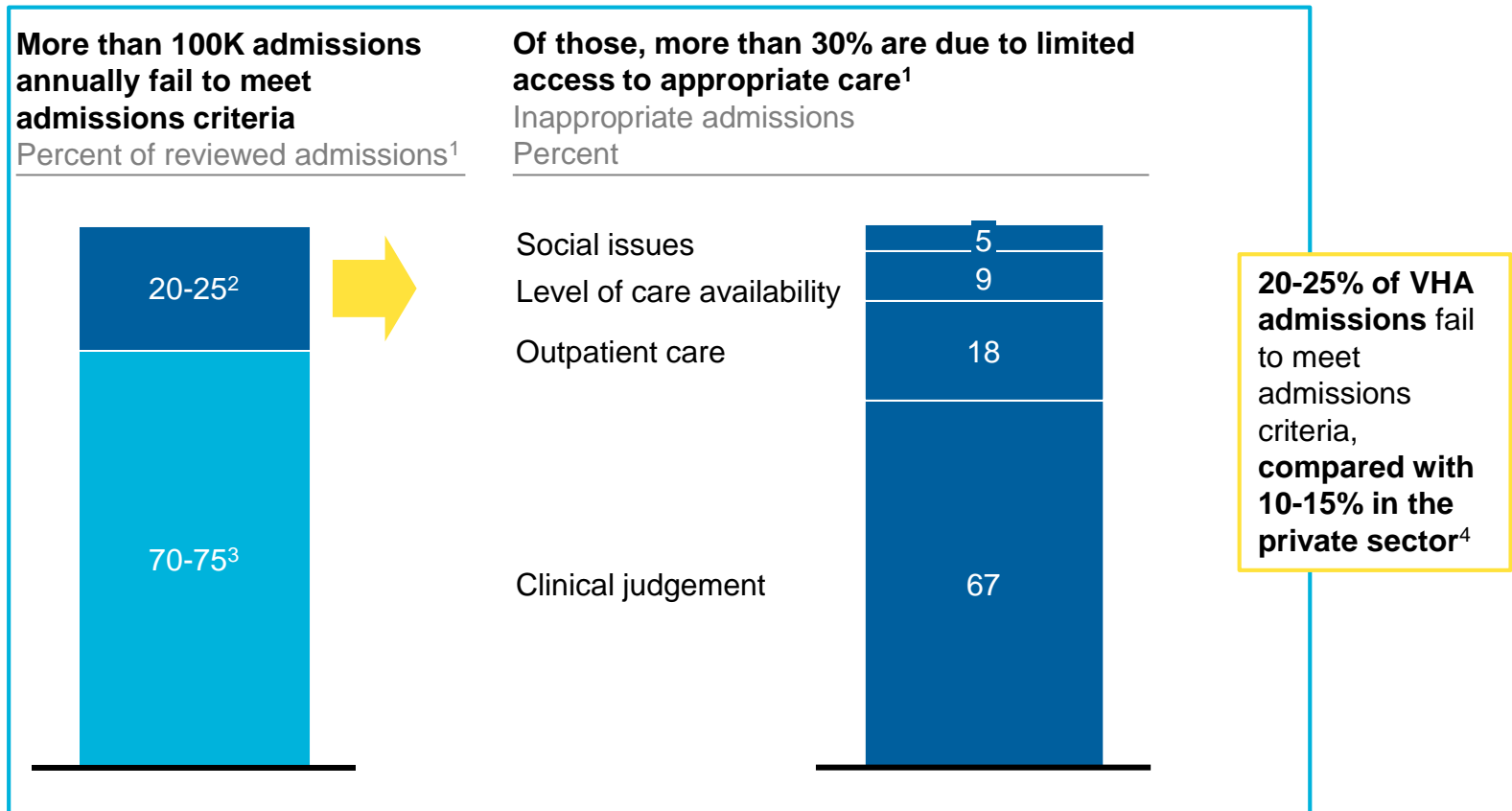
3 Total actual operating beds (e.g., actual staffed beds as reported by the facilities)

SOURCE: National Bed Control Database; Handbook on Bed Management; Choice Act data call

NOTE: Figure 6-1 in Assessment F report

② Access to care: Inpatient admissions for patients with limited access to sub-acute care hinder access and patient flow

■ Admissions that fail to meet InterQual criteria
■ Admissions that met InterQual criteria



1 NUMI estimates that 93% of admissions are reviews

2 Admissions that fail to meet McKesson InterQual criteria due to provider clinical judgment, available level of care, non-medical (e.g., social) issues, and/or care better suited for the outpatient setting

3 Admissions that meet McKesson InterQual criteria

4 Agency for Healthcare Research and Quality – Healthcare Cost and Utilization Project cited 10% of hospitalizations are potentially preventable for acute and chronic conditions based on 2008 data

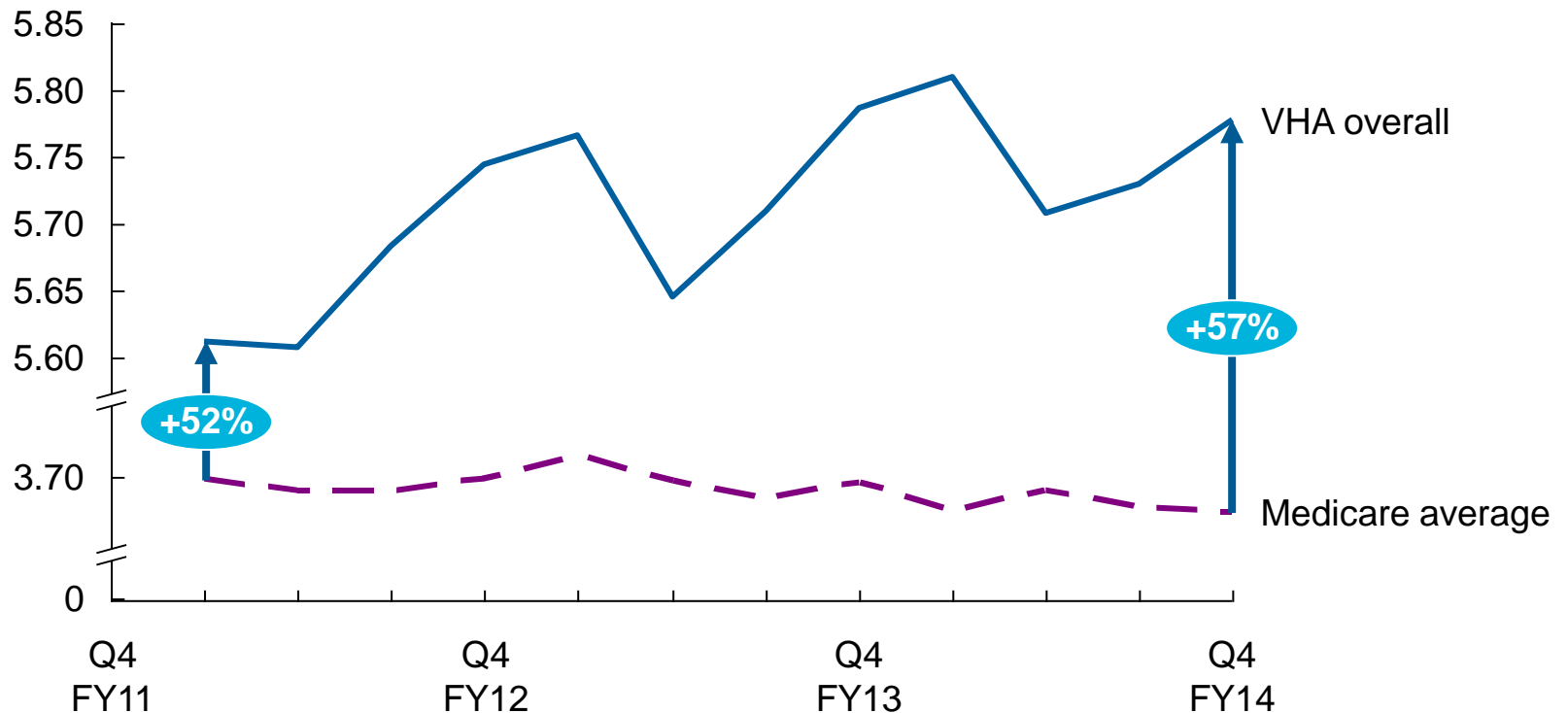
SOURCE: NUMI data (FY14); Agency for Healthcare Research and Quality (2010)

NOTE: Figure 6-3 in Assessment F report

③ LOS management: VHA national LOS compared to external Medicare average has grown during the last three years

LOS over time: VHA overall¹ vs. Medicare average²

Number of days



1 VHA LOS is based on encounter-level data from the Medical SAS Inpatient Dataset

2 Based on Medicare GMLOS for DRG mix treated at VHA, which does not account for prevalence co-morbidities (e.g., mental health) in the Veteran population

SOURCE: VHA Medical SAS Inpatient Dataset (2012-14); CMS Medicare Severity Weighting factors (FY2012-FY14)

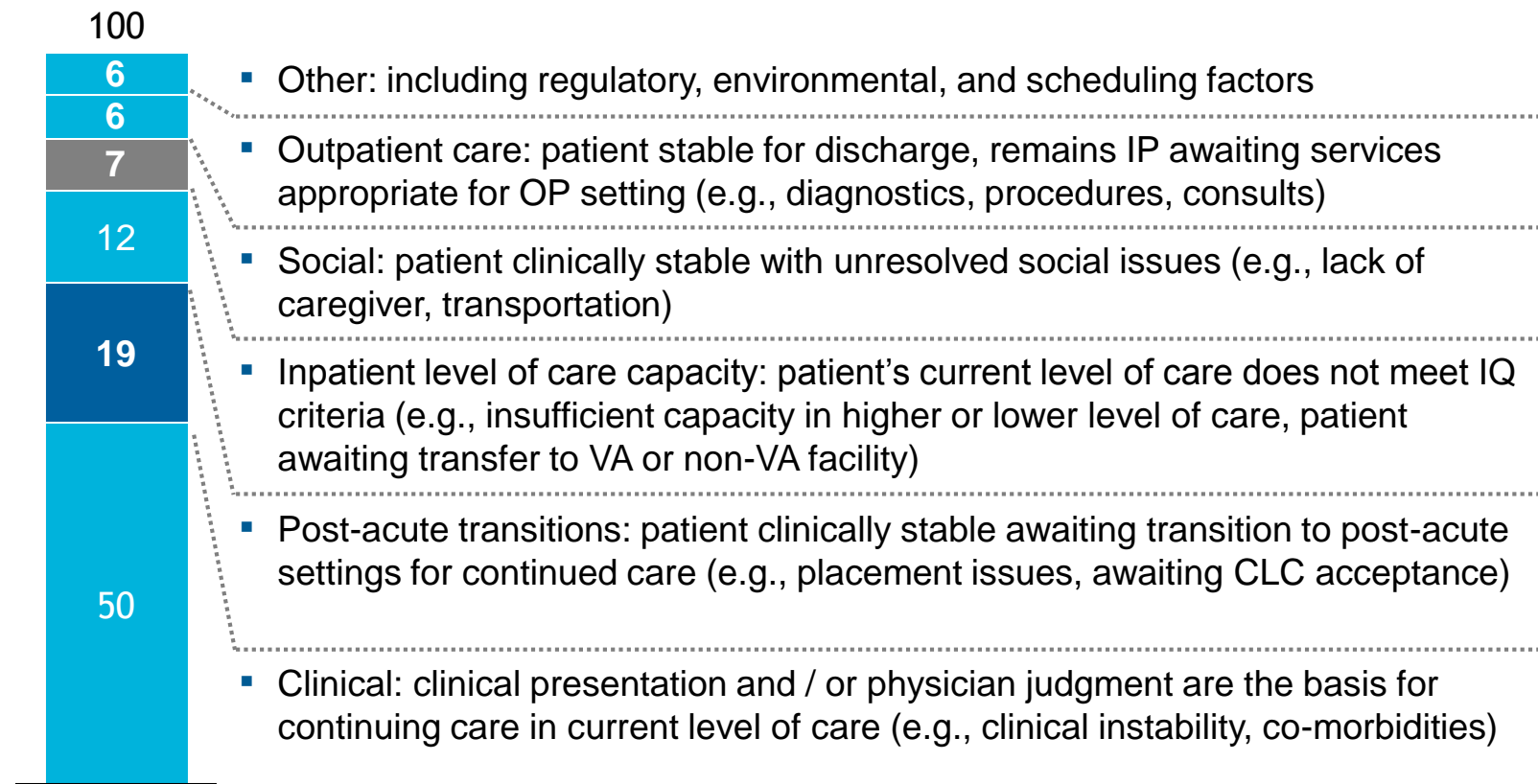
NOTE: Figure 7-1 in Assessment F report

3 LOS management: Over 25% of continued stay reviews not meeting criteria relate to post-acute placement or social issues

- Focus of 7.2.2.1 (post-acute placement)
- Focus of 7.2.2.2 (social issues)

Breakdown of reasons for continued stay reviews not meeting InterQual criteria

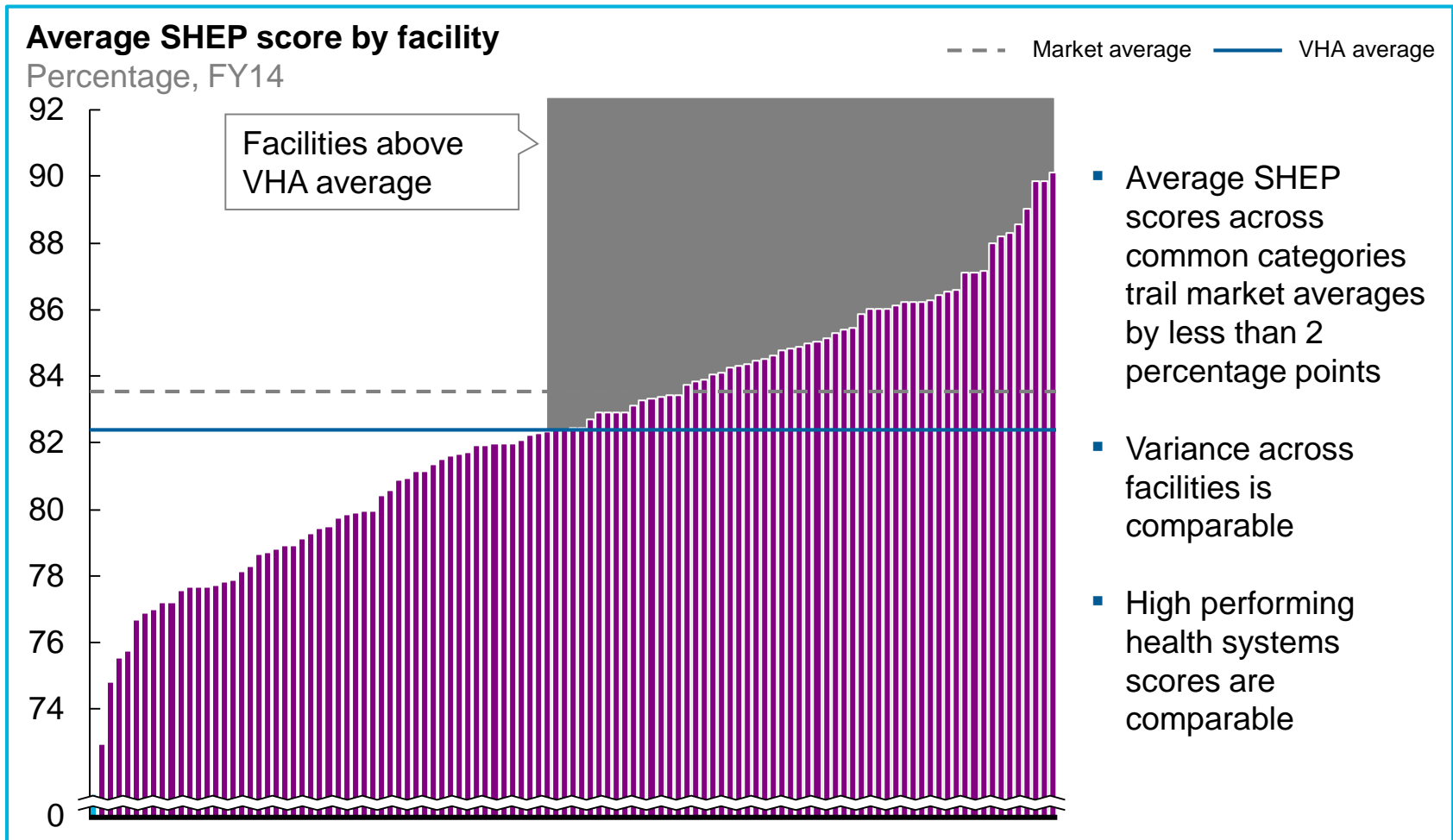
Percent of total reviews not meeting criteria (N=654,552)



SOURCE: NUMI Continued Stay Review data (FY2014)

NOTE: Figure 7-4 in Assessment F report

4 Patient experience: Variability across VAMCs indicates an opportunity to better leverage best practices from top performing facilities



1 SHEP score across all common categories evaluated by SHEP and HCAHPS

2 Average of communication with nurses, communication with doctors, communication about medication, and discharge information scores

SOURCE: CMS HCAHPS (FY 14); SHEP (FY14)

NOTE: Figure 8-2 in Assessment F report

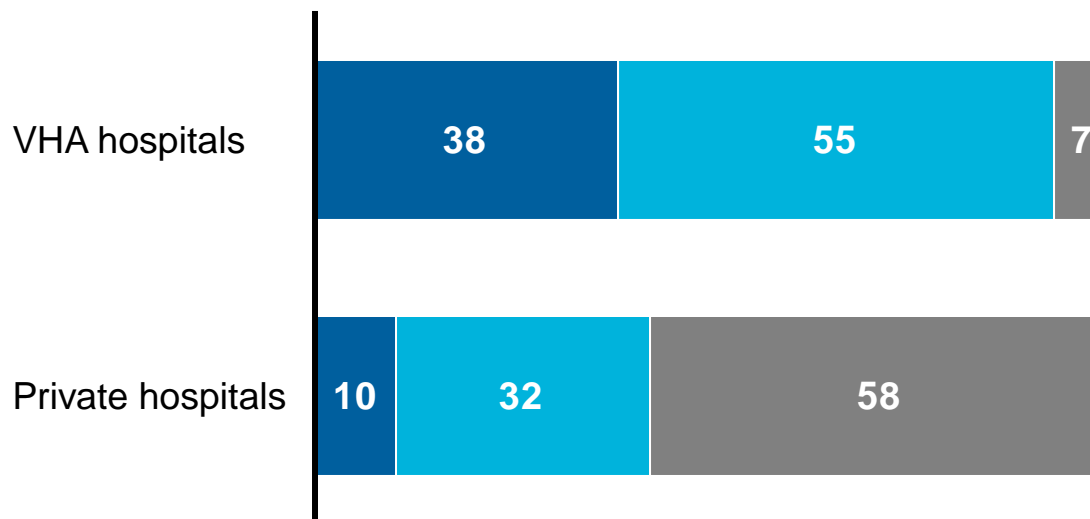
5 Documentation and coding: VHA provider responsiveness to queries lags private sector

Provider query responsiveness – VHA¹ vs. private hospitals²

Percentage of facilities (N=100 VHA hospitals, 382 private hospitals)

Responsiveness ratings,
by provider response rates

- Low: <50%
- Medium: 50-80%
- High: >80%



However, coding performance typically meets or exceeds private sector benchmarks

¹ VHA data from the Physician Query Tracking (PQT) tool

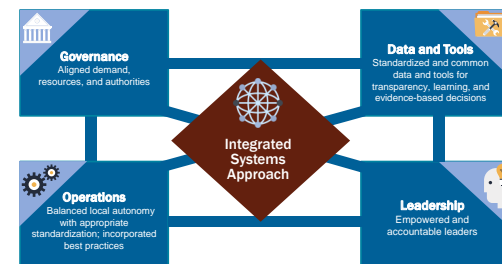
² Private sector benchmarks from Association for Clinical Documentation Improvement Specialists (ACDIS)

SOURCE: VHA Physician Query Tracking (PQT) tool (FY2014); ACDIS Physician Query Benchmarking Report (2010)

NOTE: Figure 9-4 in Assessment F report

Assessment F Recommendations

- **Ensure Resourcing (e.g., staff, facilities) Allows VHA to Serve Patients at the Appropriate Level of Care**
 - Increase timeliness of hiring for patient care teams
 - Allocate staff to match patient care need, e.g., on nights and weekends
 - Decrease the number of clinically inappropriate admissions / mitigate discharge delays due to limited access to sub-acute care
- **Scale Existing Best Practices and Support Further Innovation at the Local and National Levels**
 - Expand use of evidence-based processes for managing patient flow, e.g., ED triage, including clear role assignments and individual performance management
 - Increase local adoption of evidence-based inpatient care and discharge planning
 - Strengthen national and facility level support for patient-centered care programs to increase adoption
- **Improve Clinical Management Through Clear Operational Metrics, Streamlined Data Collection, Monitoring, and Performance Management**
 - Increase transparency of staffing by providing evidence-based staffing methodologies for all clinical staff and improving data management
 - Develop an accurate end-to-end picture of patient demand and VAMC capacity
 - Strengthen provider documentation standards (e.g., management of clinical templates) to promote optimal capture of patient information and improve resulting resource management





Preconditions for implementation to be successful

- Clearly define the range of services VHA is responsible for providing, as well as its target Veteran recipients
- Substantially streamline operational requirements and policy, including reporting requests, required programs, and earmarked funding, in order to sharpen VHA's focus and allow VAMCs the flexibility they require to address local care needs
- Understand resource implications of new and existing mandates and directives
- Increase transparency and accountability for performance against a limited set of the most important metrics



Assessment G: Provider Staffing, Productivity and Time Allocation

Conduct an assessment of the staffing level at each medical facility of the Department and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics (including case load, time spent on other than case load matters), which may include:

- i. The case load of, and number of patients treated by, each health care provider at such medical facility during an average week**
- ii. The time spent by such health care provider on matters other than the case load of such health care provider, including time spent by such health care provider as follows:**
 - i. At a medical facility that is affiliated with the Department**
 - ii. Conducting research**
 - iii. Training or supervising other health care professionals of the Department**

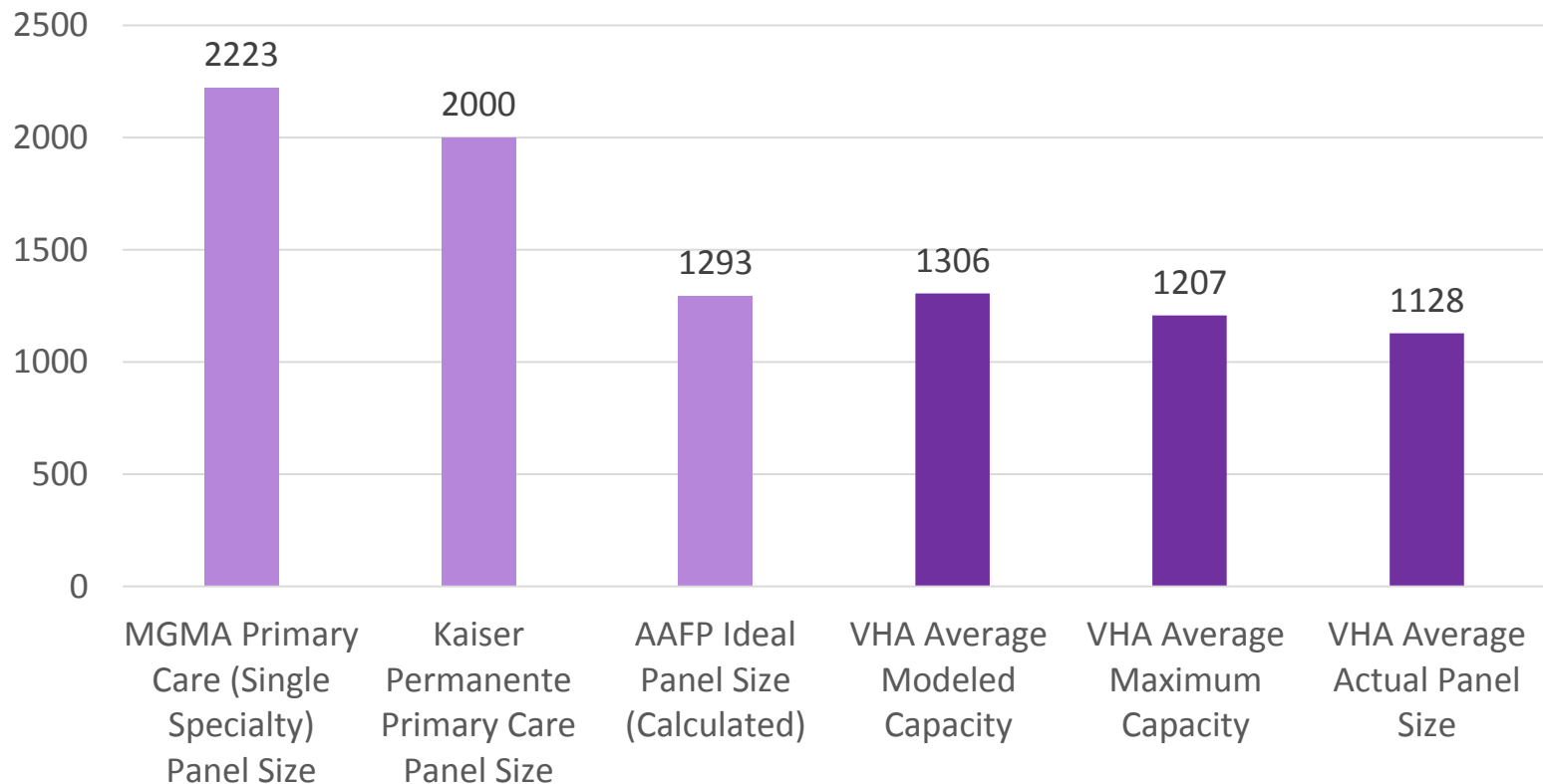


Assessment G: Summary of findings

- **Staffing mix reflects VHA's care model and the needs of Veterans**
 - More providers in medicine specialties, mental health and primary care
 - VHA does not systematically capture staffing levels of its fee-based providers
 - VHA physician FTE per population are generally lower than industry ratios
- **A productivity gap exists between VHA and private sector**
 - VHA primary care providers have smaller panels than benchmarks
 - VHA specialists are less productive, with some exceptions (i.e. psychiatry)
- **There are several reasons for this productivity gap**
 - Fewer exam rooms per provider
 - Fewer clinical support staff per provider
 - Poor staff absence coverage
- **Provider clinical time allocation is comparable to the private sector**

VHA primary care providers have smaller panels than internal and external benchmarks

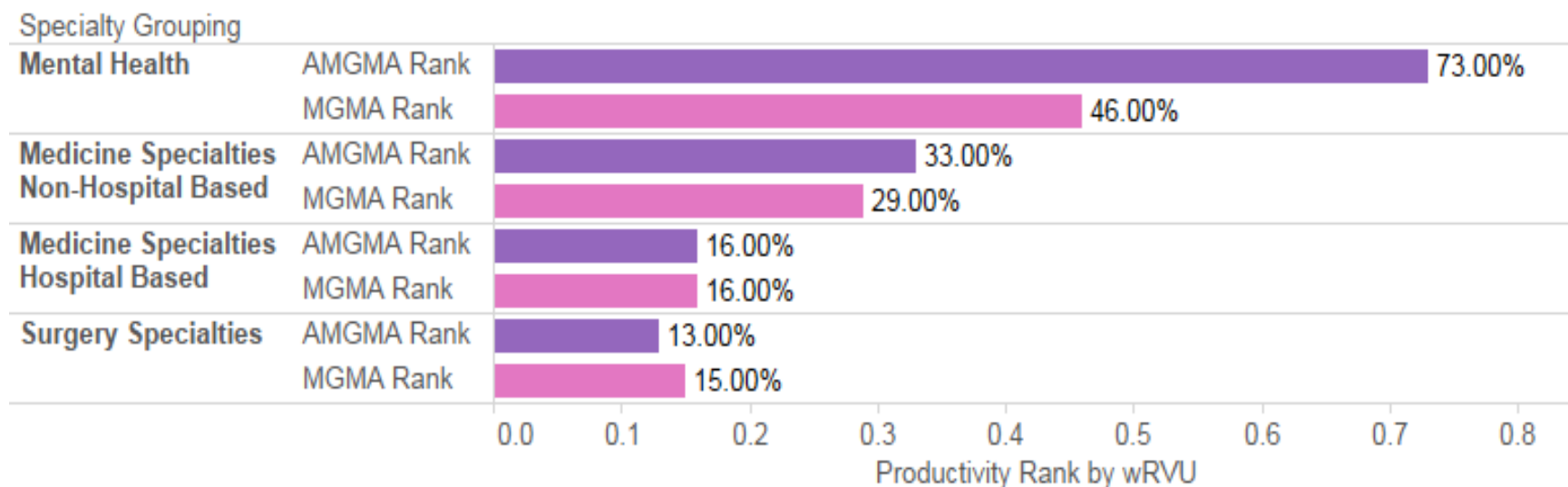
Sept 2014 VHA Physician Panel Size Comparisons per 1.0 FTE -
General Primary Care



Additional detail provided in section 2.3.5 of the report, page 46

VHA specialty care providers are less productive than the private sector, with some exceptions

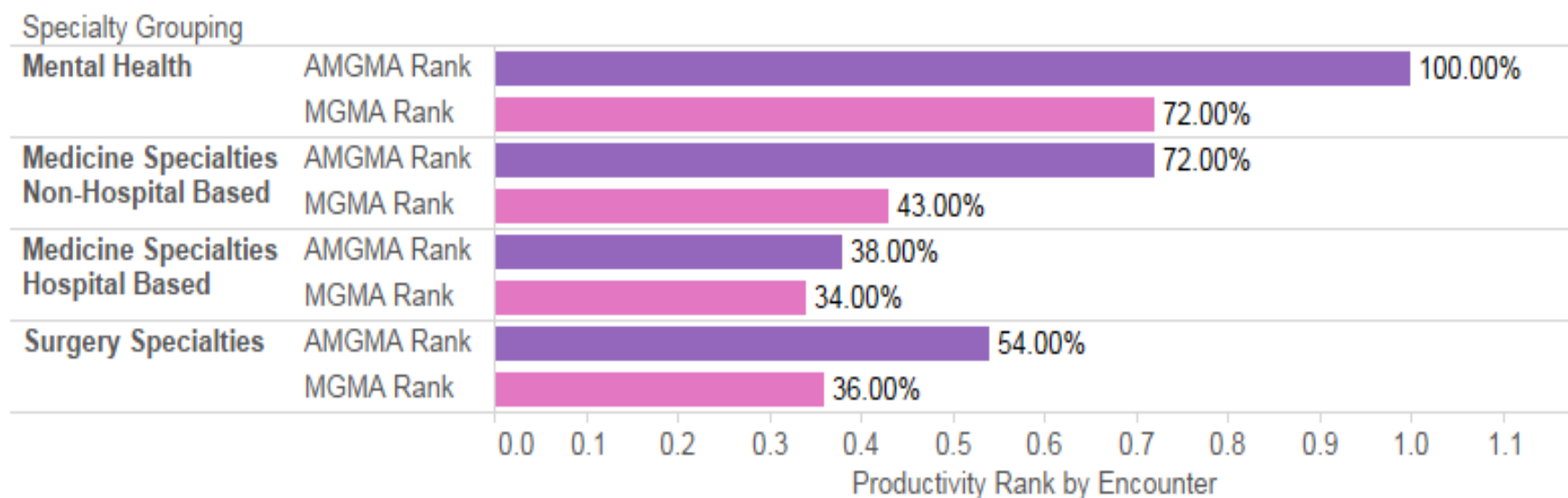
VHA's FY14 External Productivity Rankings By Work Relative Value Units (wRVUs)



Additional detail provided in section 2.3.6 of the report, page 60

VHA specialty care providers are less productive than the private sector, with some exceptions

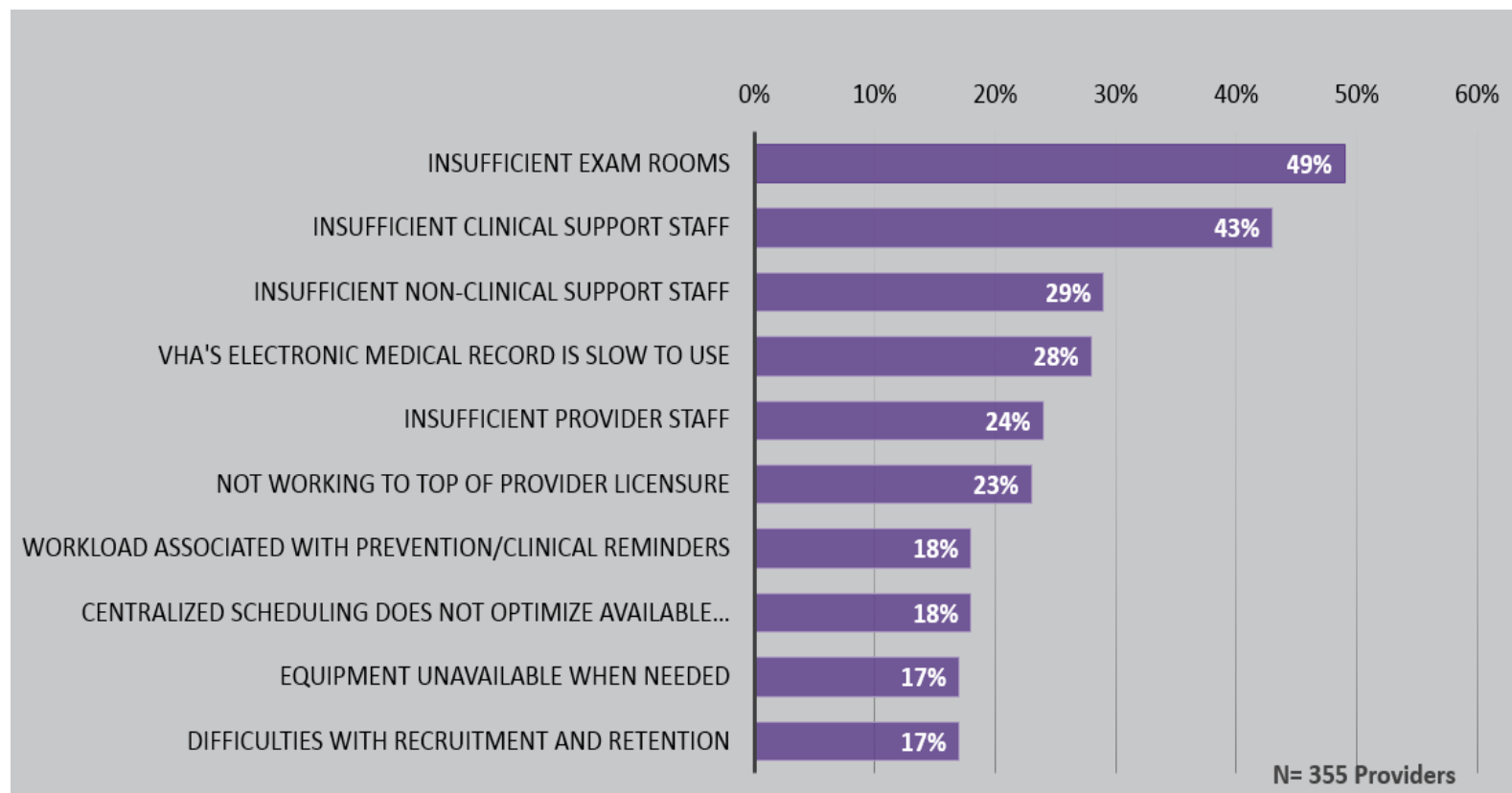
VHA's FY14 External Productivity Rankings By Encounters



Additional detail provided in section 2.3.6 of the report, page 60

Several operational constraints or barriers may explain the differences in VHA provider productivity

Most Common Productivity Issues Or barriers According To VHA Providers



Additional detail provided in section 2.3.8 of the report, page 82

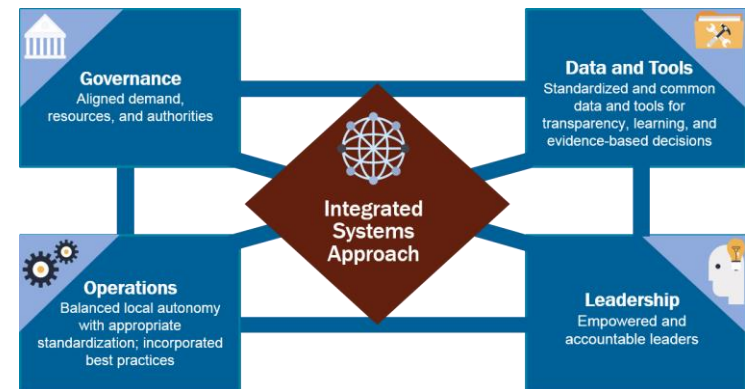
Assessment G: Recommendations

1. VHA should improve staffing models and performance measurement

- Evaluate current staffing models and develop outpatient specialty care staffing models, where few currently exist
- Improve performance measurement systems for productivity and staffing
- Incorporate fee-based providers in productivity measurement
- Fully implement the nurse staffing model and complete development of the APP productivity cube

2. Create role of clinic managers and drive more coordination and integration among providers and support staff

- Create the role of clinic manager for specialty clinics within each medical center
- Create more coordination using strategies such as: multidisciplinary clinic management teams or single/dual reporting lines or a service-line operating model



Additional detail provided in section 3 of the report, page 129



Assessment G Recommendations

- 3. Implement strategies for improving management of daily staff absences**
 - Assess the appropriate mix of staff for inpatient care based on census variation
 - Implement a float pool for inpatient and outpatient clinics
 - Include a replacement factor in staffing models

- 4. Implement local best practices that mitigate space shortages within specialty clinics. Consider strategies such as:**
 - Expanded clinic hours of operation
 - Standardized schedule templates to optimize use of exam rooms
 - System redesign to improve patient flow within clinics
 - Increase use of non face-to-face encounters
 - Change return visit intervals when appropriate or change the mode of return visit
 - Develop exam room ratios to meet needs of staffing models



Assessment J – Supplies

Conduct an assessment of the “The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Department, including the following:

- i. The prices paid for, standardization of, and use by the Department of the following:
 - Pharmaceuticals
 - Medical and surgical supplies
 - Medical devices
- ii. The use by the Department of group purchasing arrangements to purchase pharmaceuticals, medical and surgical supplies, medical devices, and health care related services
- iii. The strategy and systems used by the Department to distribute pharmaceuticals, medical and surgical supplies, medical devices, and health care related services to Veterans Integrated Service Networks and medical facilities of the Department”



Assessment J – Supplies

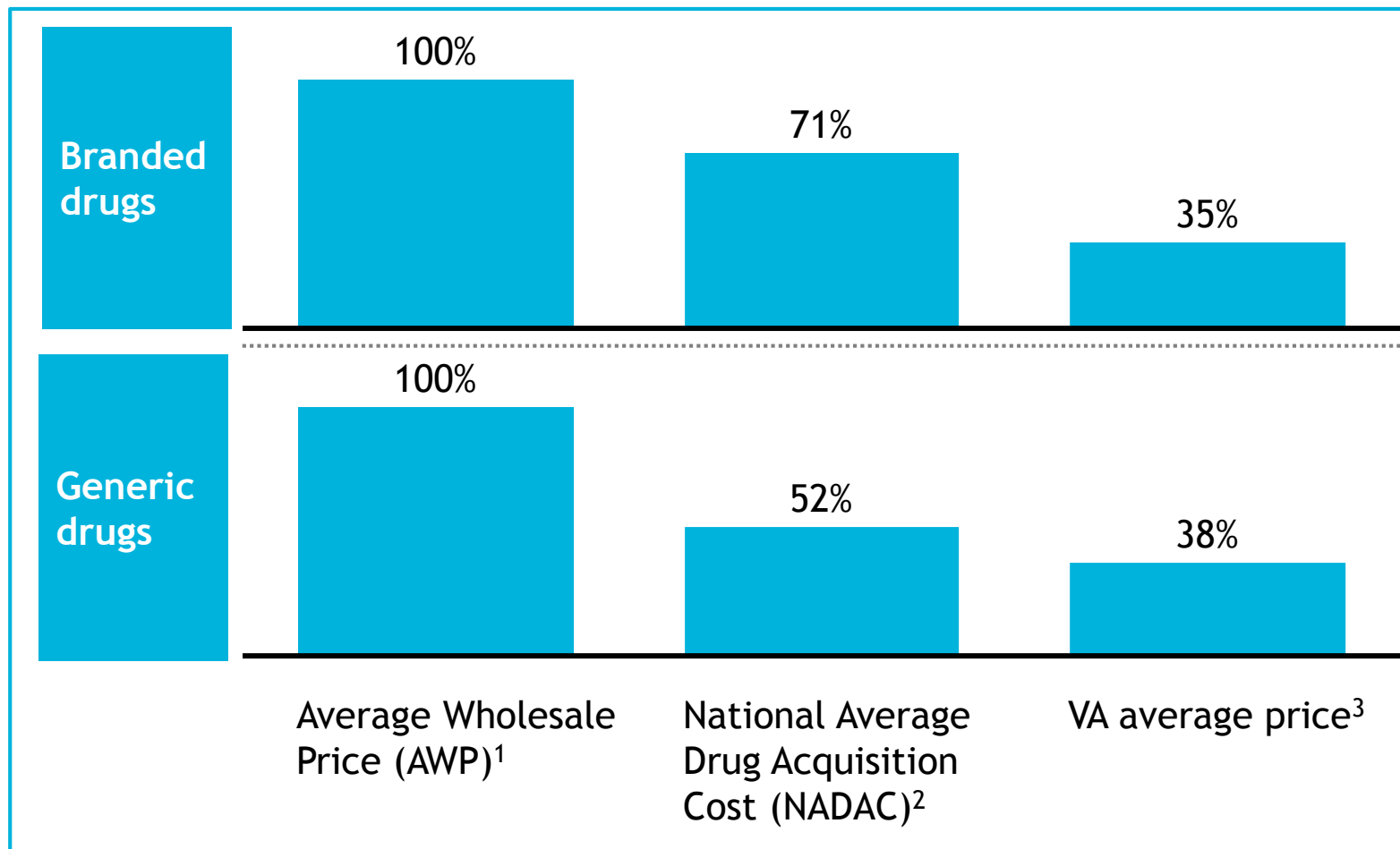
Summary of findings

VA's supply chain performs well for pharmaceuticals and poorly for medical and surgical supplies and medical devices

- 1 For pharmaceuticals
 - A VA pays relatively low prices for drugs, though potential to improve in some pockets
 - B Has a robust and efficient pharmaceutical distribution network that achieves high satisfaction scores
 - C Has mechanisms in place to ensure appropriate utilization of medications
- 2 For medical and surgical supplies, medical devices, and related services
 - A VA's contracting processes are bureaucratic and slow
 - B Purchasing workarounds to meet timing of patient care lead to inefficiencies
 - C Utilization is difficult to measure and manage given poor data and systems

1A Overall, VA pays low prices for its drugs

Average unit price per pill as a percent of AWP



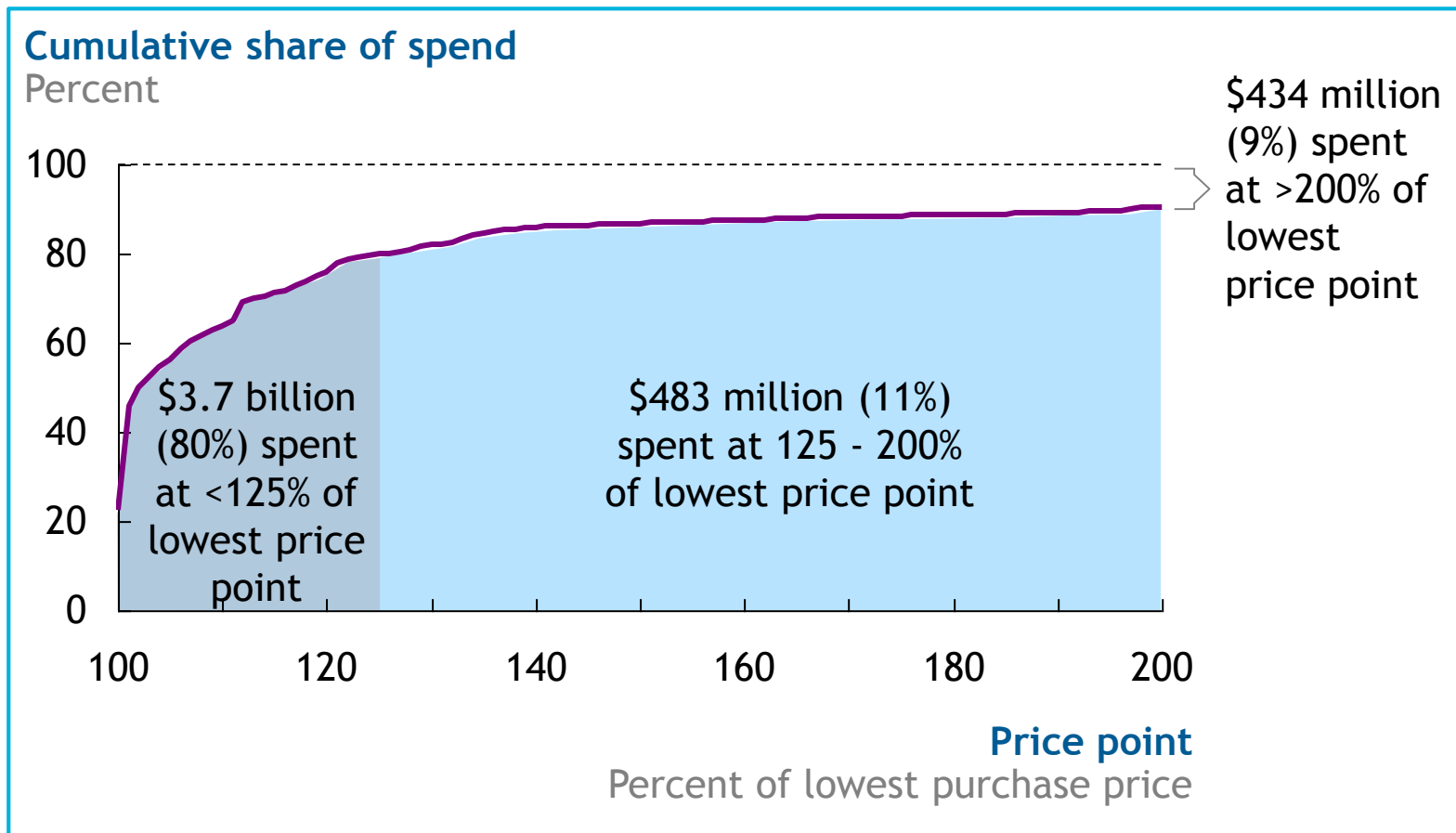
1 Average Wholesale Price information included in VA purchase data

2 National Average Drug Acquisition Cost (NADAC) is a government drug price index based off aggregated invoice surveys from retail pharmacies

3 Weighted average price per pill for each National Drug Code (NDC) purchased in April 2014, data only includes tablets and capsules, excluded drugs with NADAC price change in April 2014, n = 926 branded NDCs, 191 generic NDCs

SOURCE: VHA Pharmacy Benefits Management; NADAC data available at <http://www.medicaid.gov>

1A However, VA still buys a significant proportion of drugs above the lowest available price^{1,2}



1 Includes all generic and branded drugs, CY2014. Lowest price point defined as lowest cost per pill for an individual transaction

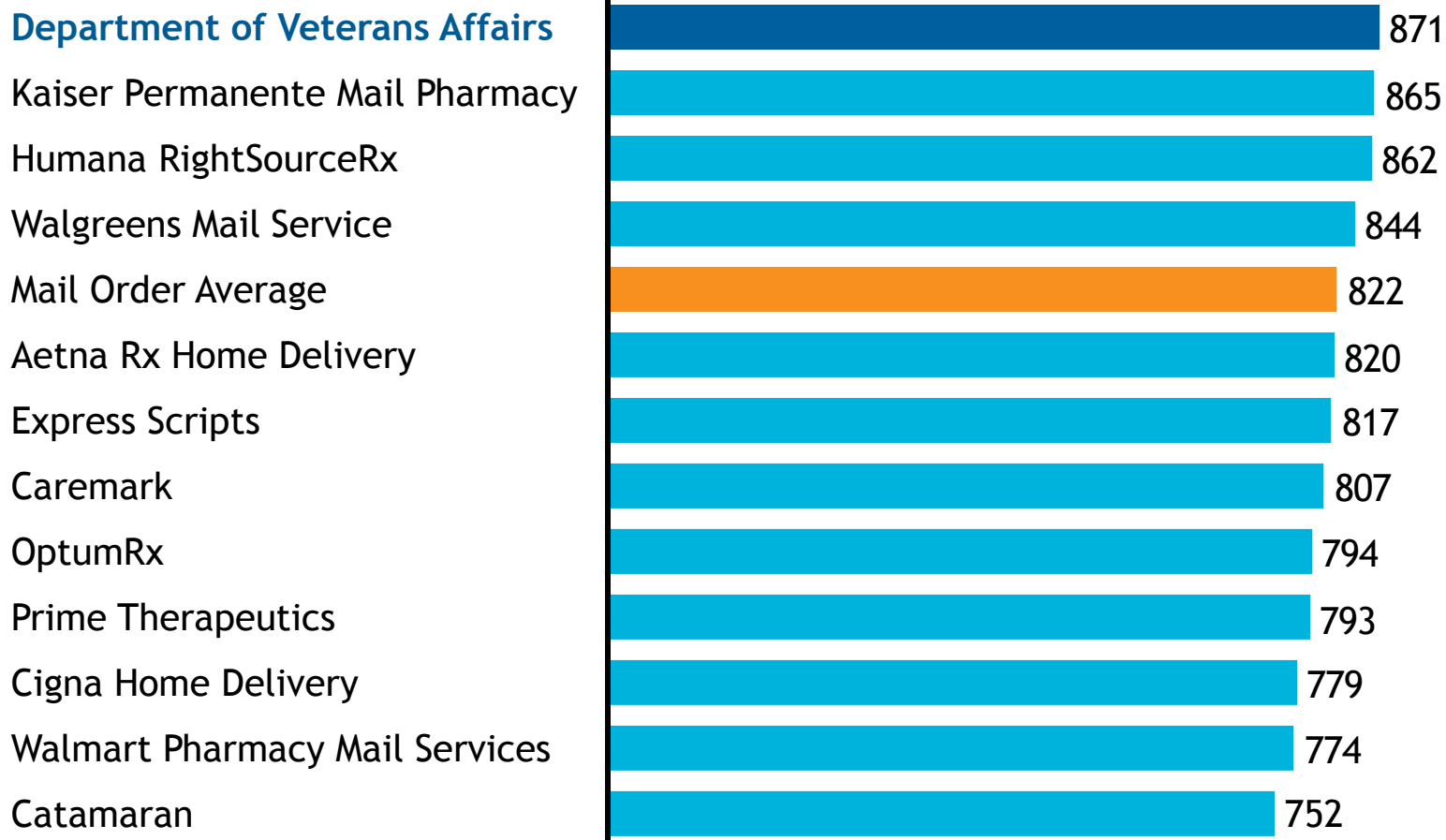
2 Low outliers and high outliers excluded. Low outliers defined as a price point <10% of the average price point. High outliers defined as a price point equal to 1000% above average price point for the year (volume weighted)

SOURCE: VHA Pharmacy Benefits Management

1B Veterans are highly satisfied with VA CMOP service

Results of 2014 J.D. Power's Pharmacy Overall Satisfaction Study (mail order)

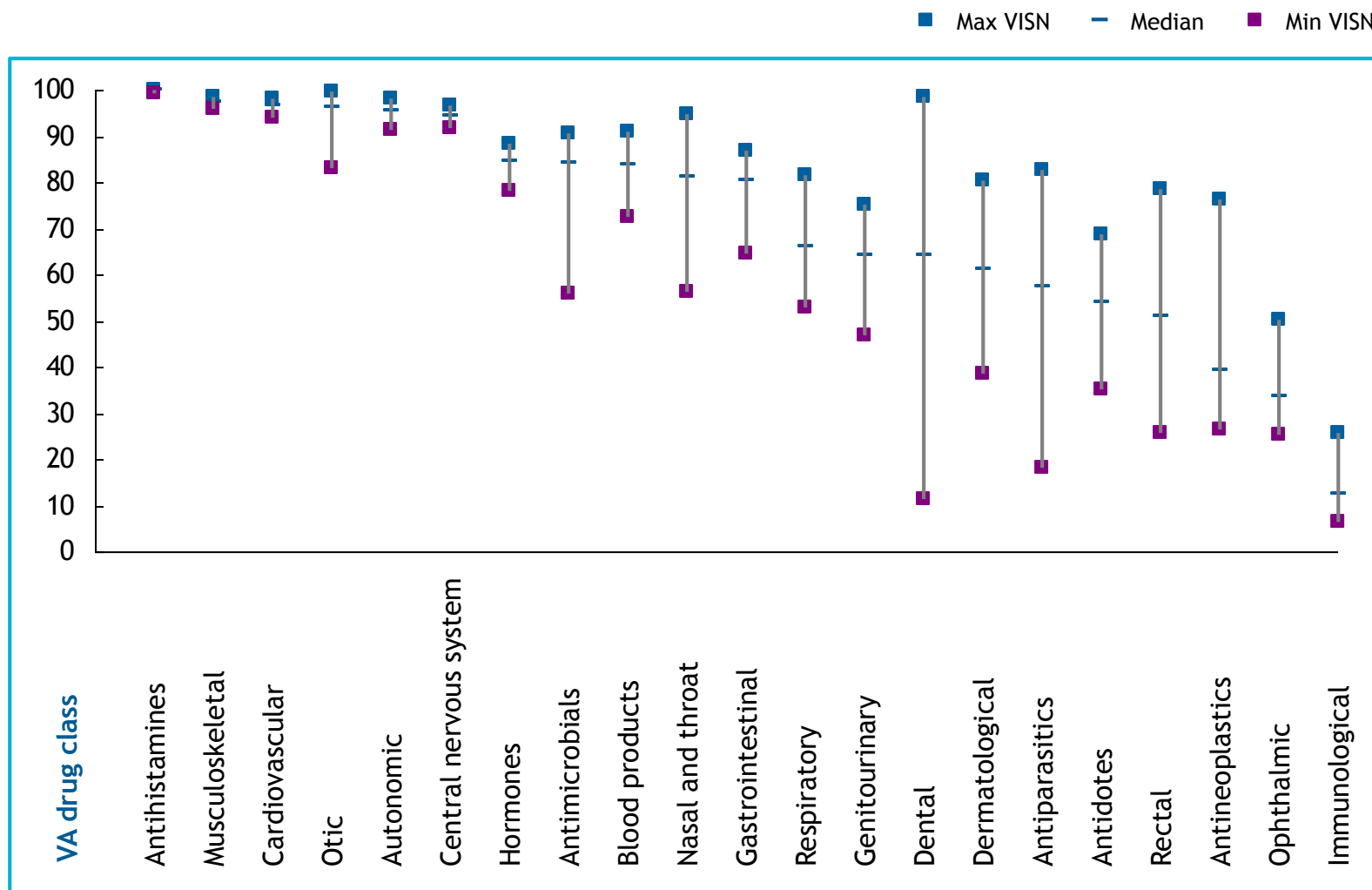
Points out of 1,000



SOURCE: JD Power Mail Order Pharmacy Rankings – Overall Satisfaction, 2014, data collected from VA CMOP leadership

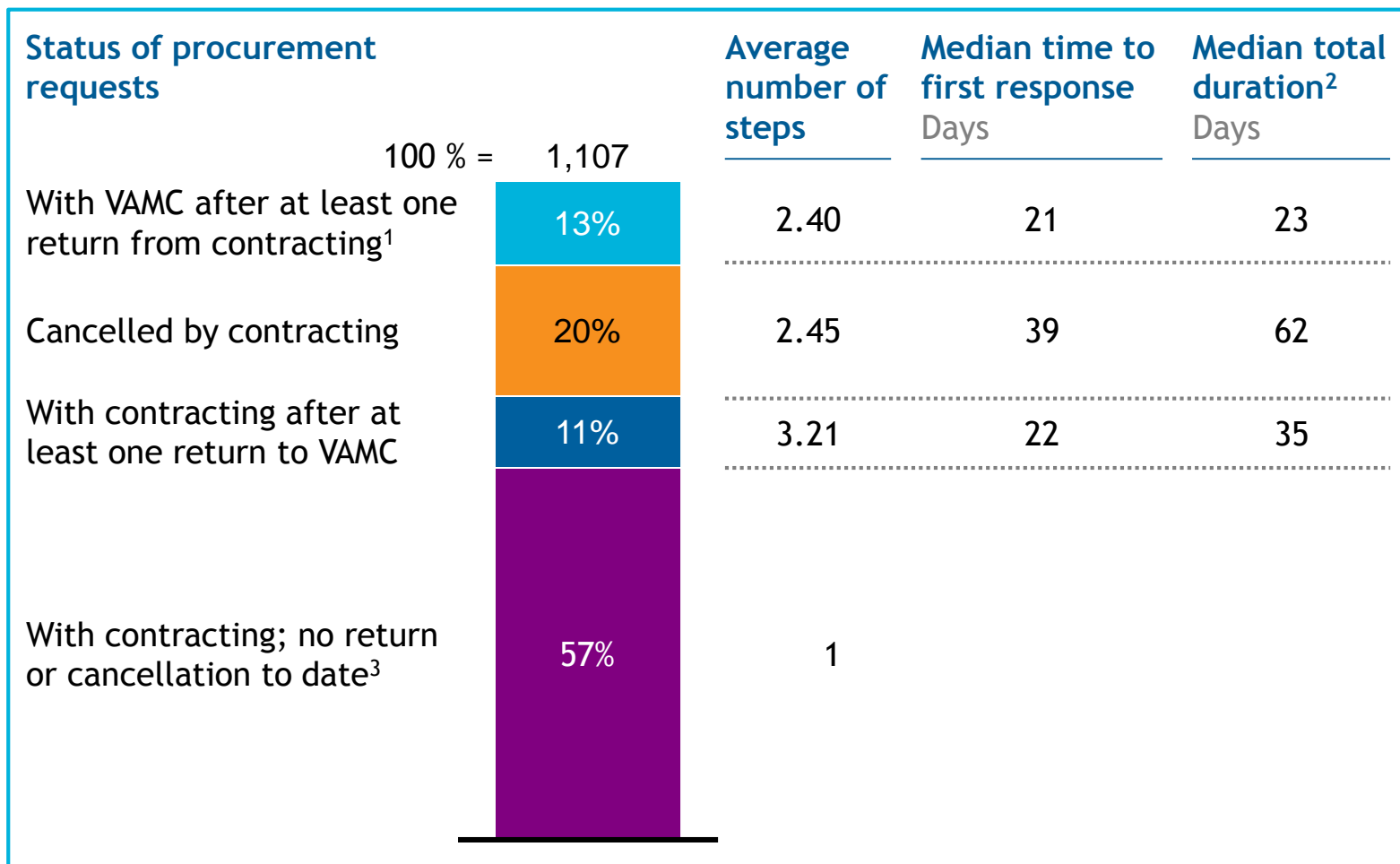
1C Generic purchasing rates are high overall, but vary by drug class and between VISNs

Percentage of pills or pill equivalents purchased that are generic



SOURCE: VHA Pharmacy Benefits Management

2A For med / surg supplies, there are long response times for procurement requests with issues



1 Returned to Accountable Officer or Control Point in VAMC

2 From first submission to final status

3 Final disposition (awarded or not) was not determined

SOURCE: Data provided by VAMC during site visit

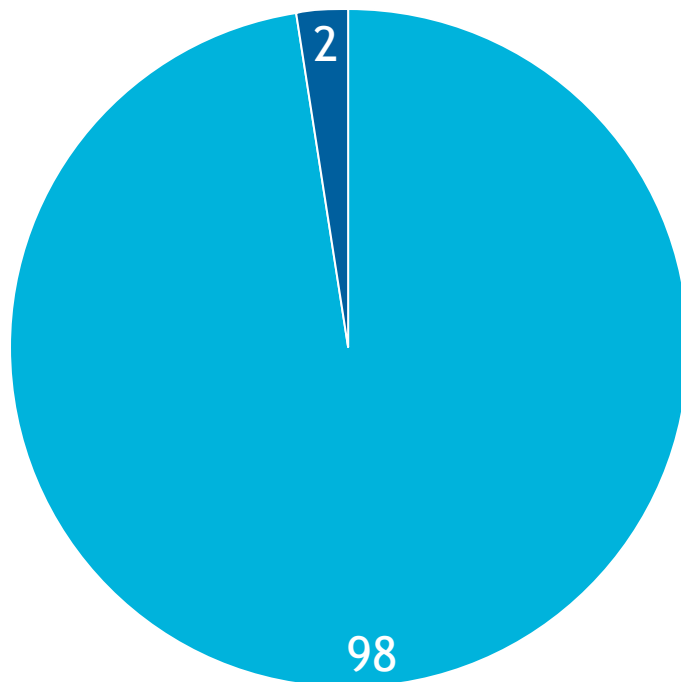
2B 98% of clinical supply transactions in five VISNs were made with purchase cards

Purchase card
Other

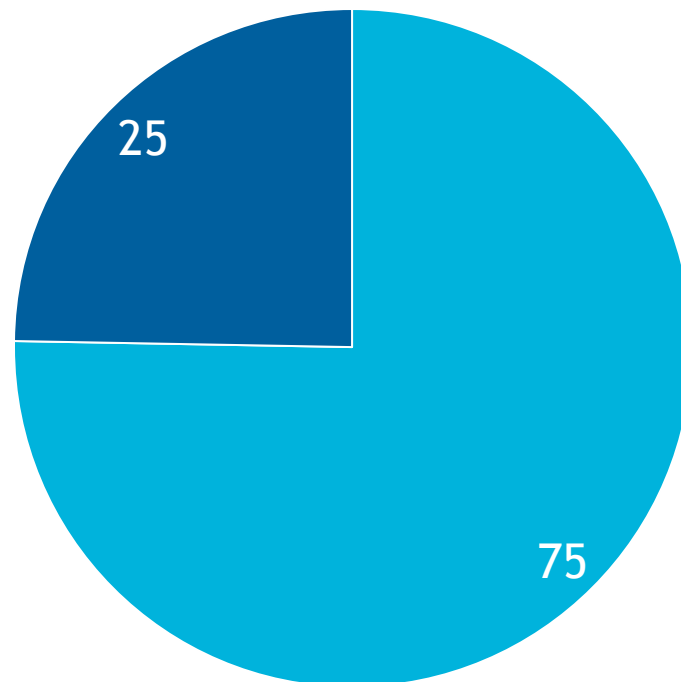
Transactions on purchase cards versus other forms of payment

Percent

Based on number
of purchase orders



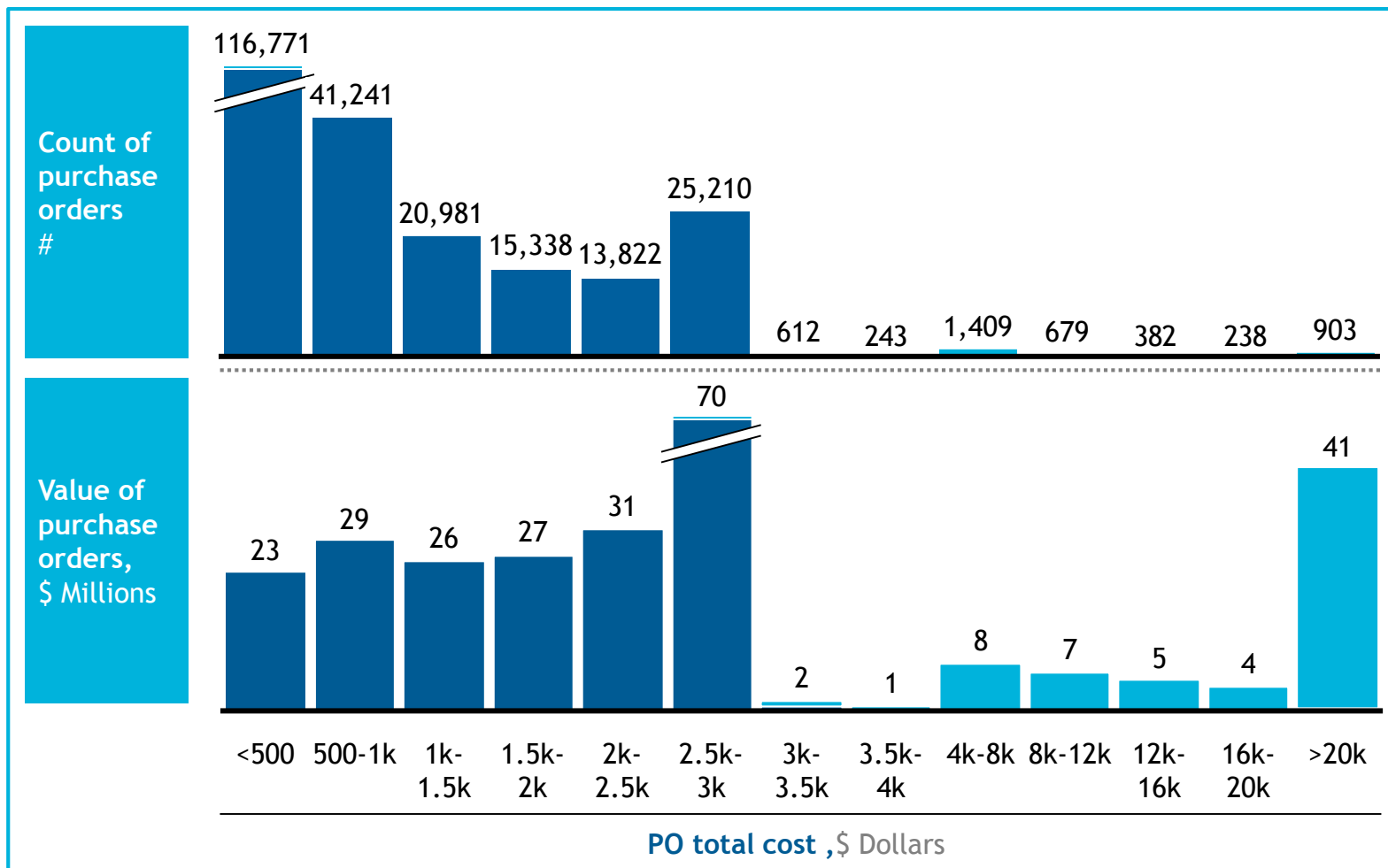
Based on spend



SOURCE: VHA Procurement and Logistics Organization, IFCAP data; transactions for BOC 2632 across 5 VISNs; FY2014

2B There are disproportionately more purchases within \$500 of the micro-purchase threshold

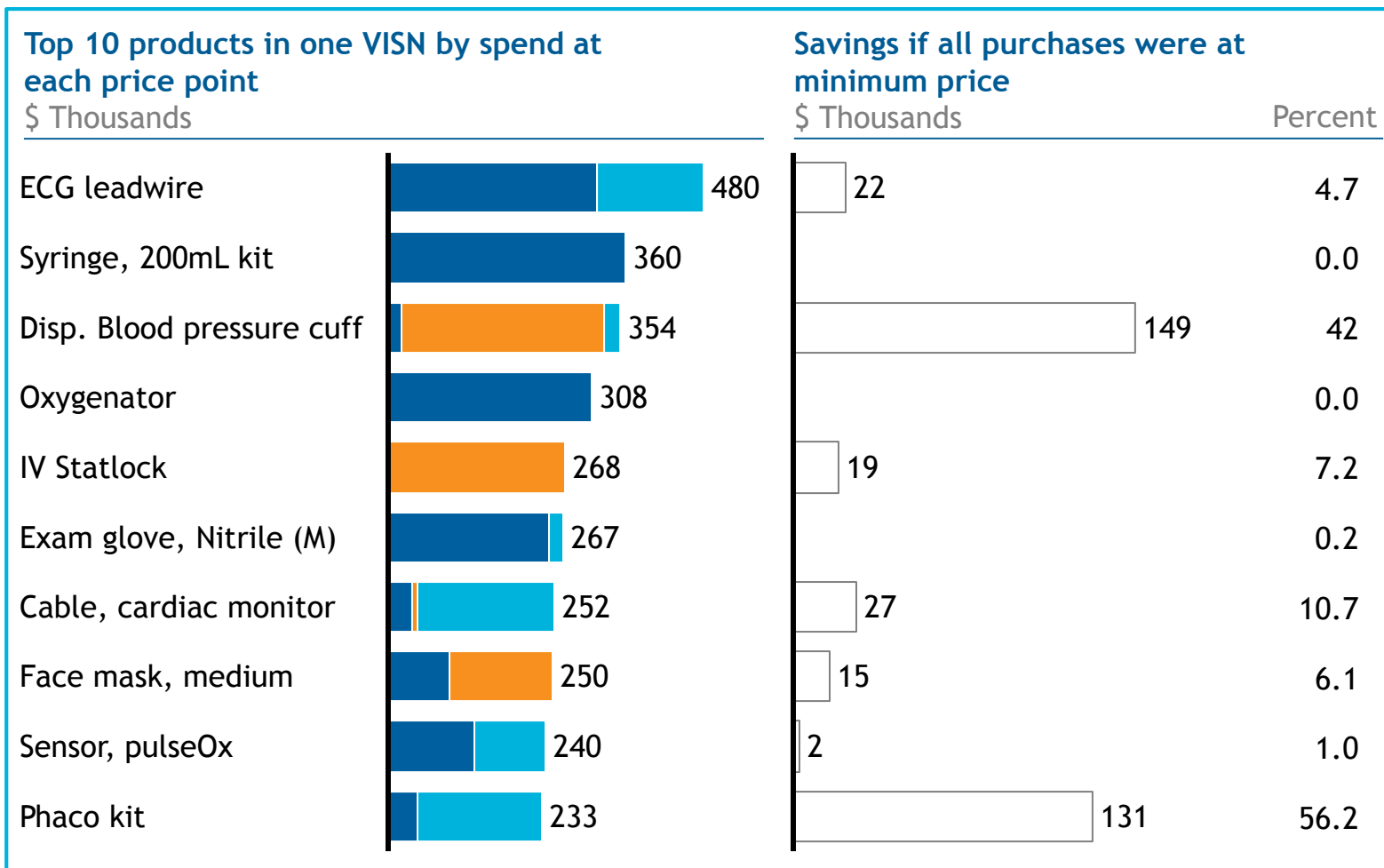
Method of processing

■ Invoice/other ■ Purchase card


SOURCE: VHA Procurement and Logistics IFCAP data, all purchase orders with BOC 2632 from FY2014 for five VISNs

2B Variation in purchase prices for same items leads to additional costs for clinical supply products

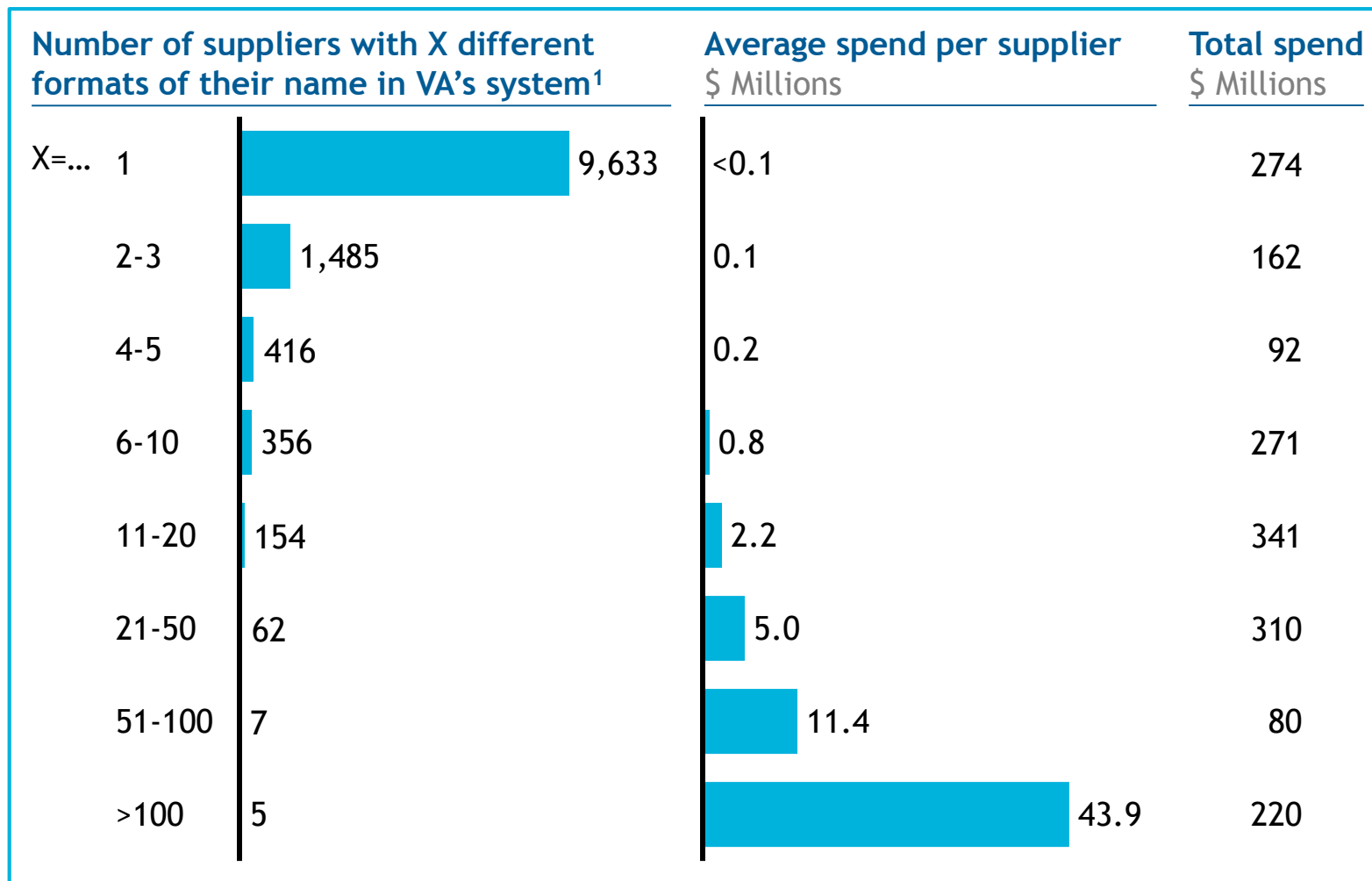
Low price Middle prices¹ High price



1 Some products had more than one mid-price point; the total spend for all middle prices is shown

SOURCE: VHA Procurement and Logistics Organization, IFCAP FY14 medical and surgical supplies purchases for one VISN (total spend in FY14 of \$91 M)

2C Inconsistent data entry has led to vendor name proliferation, which hinders utilization management



1 Equivalent pairs of vendor names from FY2014 prosthetic purchases were identified with fuzzy string matching, clustered and manually inspected to produce sets of equivalent vendor formats. >23,000 entries were reduced to ~12,000, some additional redundancy likely remains

SOURCE: VHA Procurement and Logistics Organization

Assessment J Recommendations

Pharmaceuticals

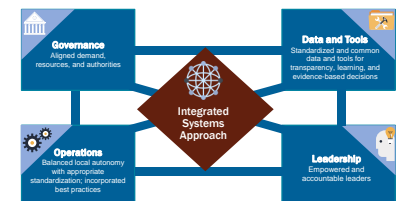


- Establish mechanisms to ensure VA secures a reliable supply of pharmaceuticals and accesses the lowest possible pricing more consistently
 - Modernize VA Acquisition Regulations (VAAR) to enable access to lower priced commercial sources when possible
 - Identify pharmaceuticals at highest risk of shortages and price spikes, and develop specific strategies to limit impact
 - Improve lifecycle management of contracts to prevent lapses

Medical / surgical supplies and medical devices



- Transform and consolidate VA's entire medical supply chain organization
 - Rationalize the organizational structure by consolidating entities into one integrated supply chain organization that manages all VA contracting and logistical management of clinical supplies and medical devices
 - Establish robust performance management of supply and device procurement that is focused on Veteran outcomes
 - Develop deep category-level expertise within the organization
- Improve key enablers required to support the organizational transformation, including IT systems, data standardization, and talent management
 - Update or replace supply chain IT systems to make them fit for purpose
 - Standardize supply chain data and overlay user-friendly interfaces that enable robust and timely decision-making
 - Revise VA's approach to talent management





Assessment K – Facilities

Conduct an assessment of the process of the Department for carrying out **construction and maintenance projects** at **medical facilities** of the Department and the **medical facility leasing program** of the Department:

- Review the processes of the Department for identifying and designing proposals for construction and maintenance projects at medical facilities of the Department and leases for medical facilities of the Department
- Assess the process through which the Department determines the following:
 - That a construction or maintenance project or lease is necessary with respect to a medical facility of the department
 - The proper size of such medical facility or proposed medical facility with respect to treating Veterans in the catchment area of such medical facility or proposed medical facility
- Assess the management processes of the Department with respect to the capital management programs of the Department, including the processes relating to the methodology for construction and design of medical facilities to the Department, the management of projects relating to the construction and design of such facilities and the activation of such facilities
- Assess the medical facility-leasing program of the department

In addition to those areas directly specified by the legislation, we have included two additional areas of focus:

- Facility management program
- Long term capital funding requirements of VHA



Assessment K – Facilities

SUMMARY FINDINGS

- 1 The capital required to maintain VHA facilities and meet projected needs over the next decade is likely two to three times higher than anticipated funding levels (\$51 billion versus \$16-26 billion)
- 2 Capital management, design and construction, leasing, and facilities management performance is on a par with public sector performance in most cases, yet well below private sector performance. The cost per square foot to deliver major construction projects is approximately twice the private industry best practice.

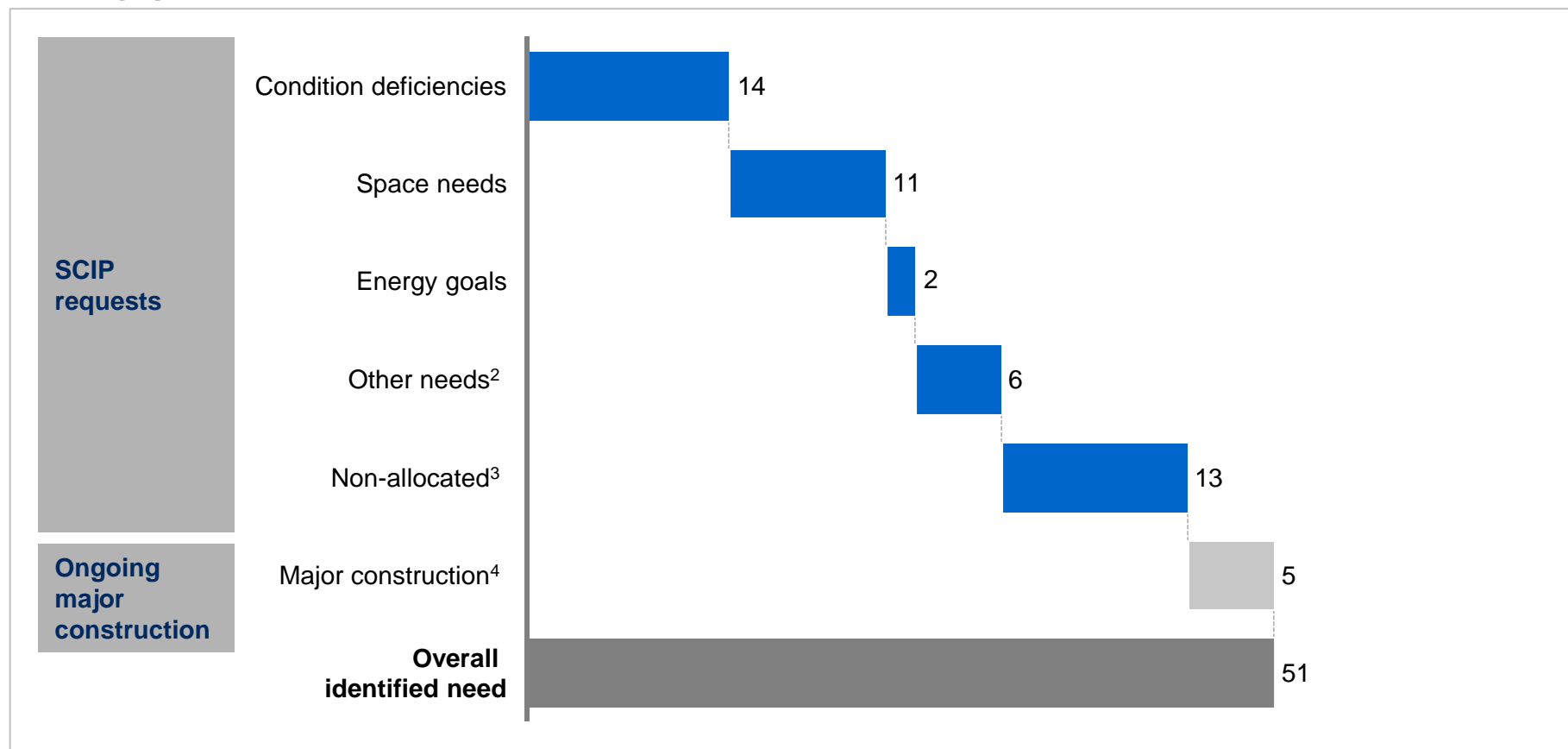
VA's ability to deliver needed projects consistently on time and on budget is hindered by a number of factors including:

- A Shortfalls in accountability, role clarity, internal communication, and proactive problem solving approaches
- B Inconsistent capital allocation to projects that address the greatest areas of Veteran need in the most cost effective and timely manner
- C Frequent changes to scope and design criteria for major projects

1 VHA estimates ~\$51 bn funding need for the next 10 years from FY16 SCIP requests and outstanding major construction budget requests

VHA funding requests for FY2016-FY26¹

Billions



1 Funding requests aligned to primary gap identified in Strategic Capital Investment Plan (SCIP) submission

2 Including functional, access, and utilization needs, as defined in SCIP

3 Anticipated needs currently defined by out year funding amounts which will allocated across need types as projects are designed

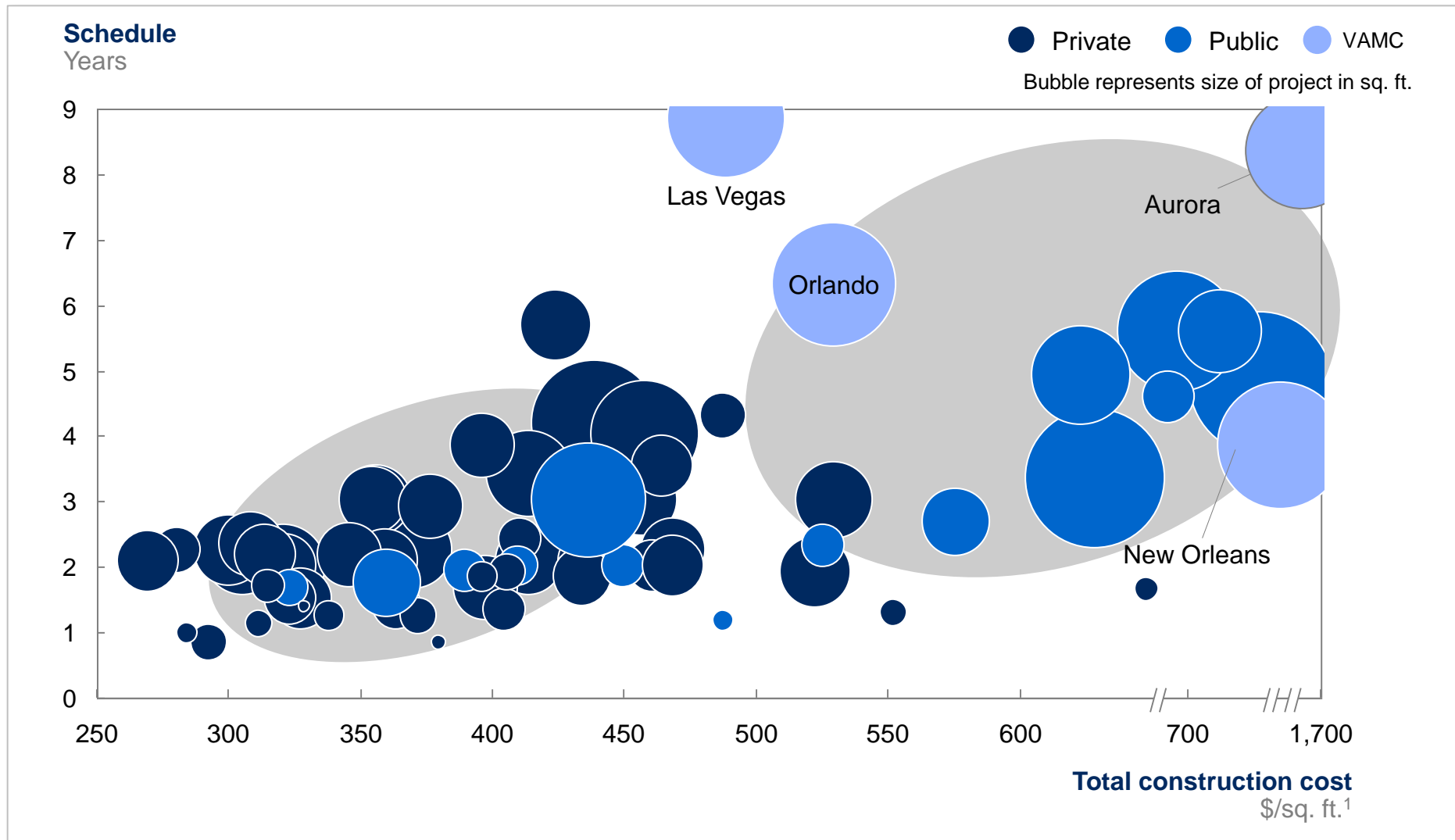
4 Request for on-going major construction projects for FY16 and beyond, as reported in FY16 VA Budget

5 Calculated number, projecting standard post-contract overruns on major construction dollars projected in FY16 budget and ranging cost overruns on major construction requests in SCIP submission between historic post-contract overruns and overruns over initial estimated cost

SOURCE: FY16 SCIP submissions, OAEM; FY16 VA Budget

NOTE: Figure 3-2 in Assessment K Report

2 Large public projects including VA's are up to twice as expensive as private sector projects while taking 2-3 times longer to finish



¹ Dollars / sq. ft. adjusted to 2015 via internal factors for Design Cost Data Factors and ENR indices for others; adjusted to U.S. Nat'l avg. via RS Means CCI (2014 & 2013)

SOURCE: Internal cost benchmarking studies, proprietary construction databases, public websites (contractors, owners, designers), Sample Size = 67 projects

NOTE: Figure 6-9 in Assessment K report

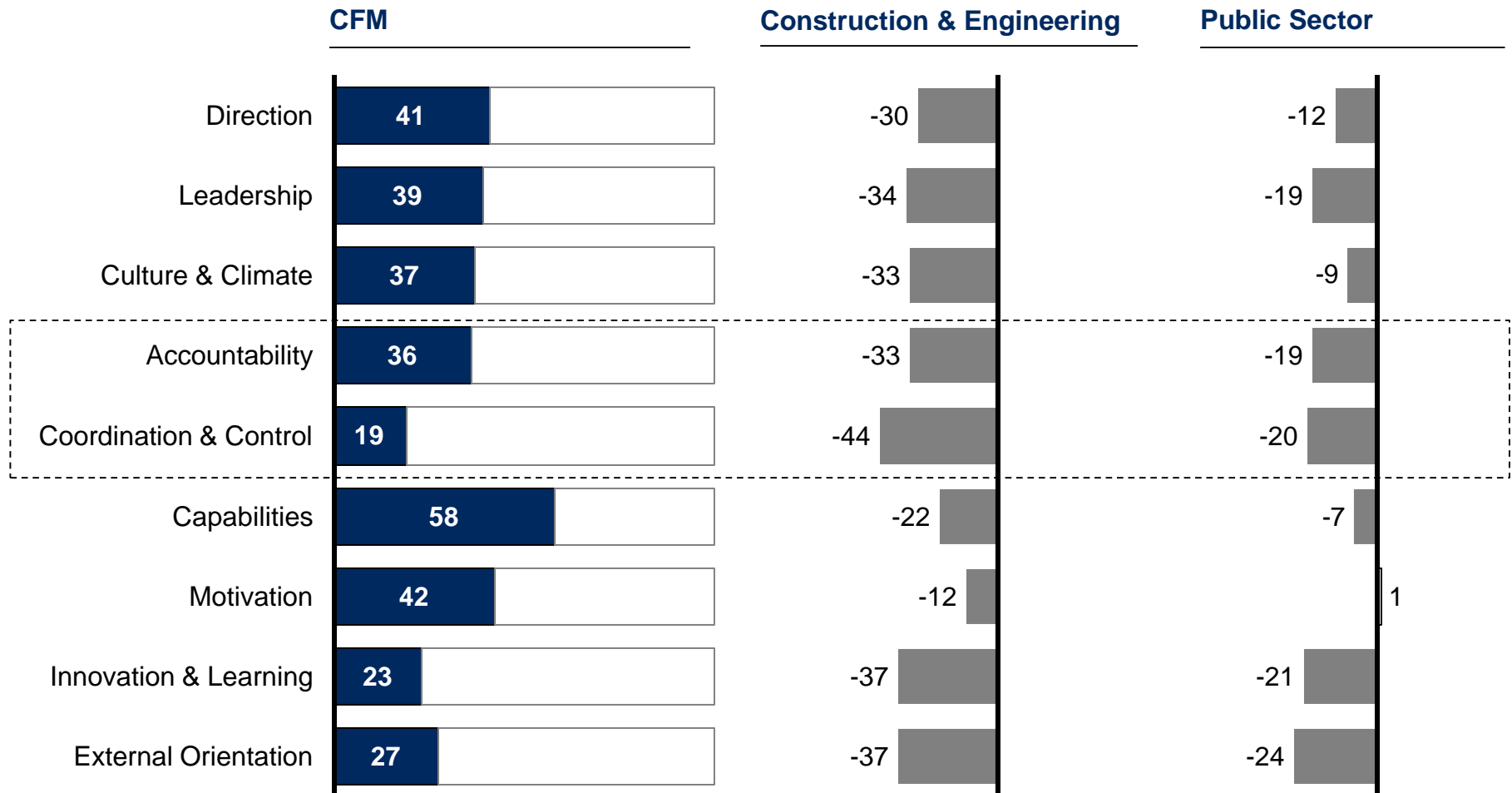
2A VA CFM organization health lags in key outcomes when compared to public and private peers

Percentage agreement on outcome effectiveness out of 100%

Difference between organization and benchmark median, percent

Comparison to benchmark

- Stronger (> +5)
- Comparable
- Weaker (< -5)



SOURCE: VA-CFM (Veterans Affairs) 2015 (N=79); Public sector benchmark (N=47,159, no. surveys=27); Construction & engineering benchmark (N=24,005, no. surveys=18)

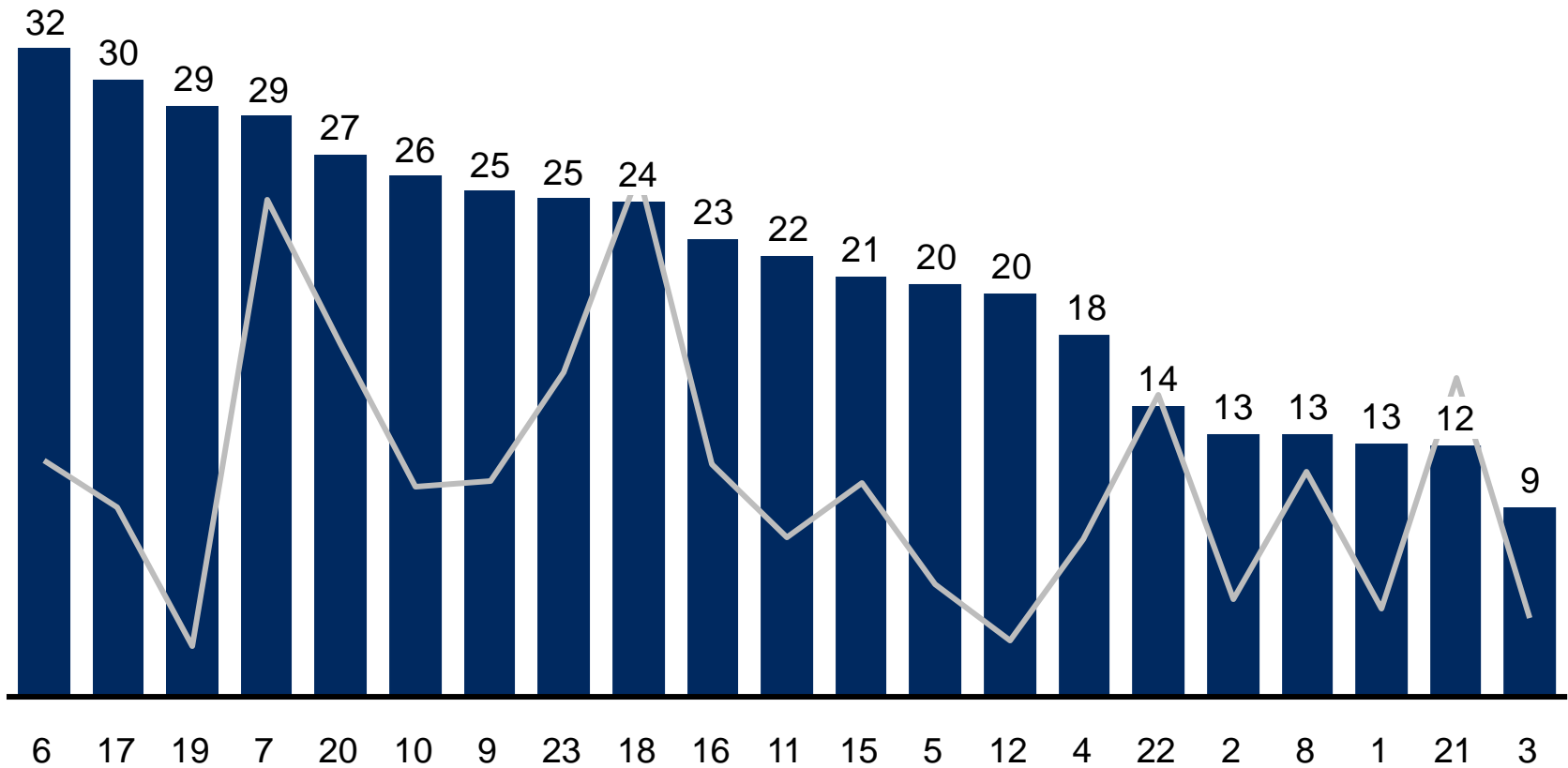
NOTE: Figure 6-23 in Assessment K report

2B Highest patient growth areas are not adding the most capacity

Outpatient space additions not matched with areas of highest growth

10 year percent change over FY14 baseline

— Percent of change in outpatient square footage
■ Percent of change in outpatient workload



VISN

1 Non-clinical space includes administrative, common, infrastructure, research and swing/construction space

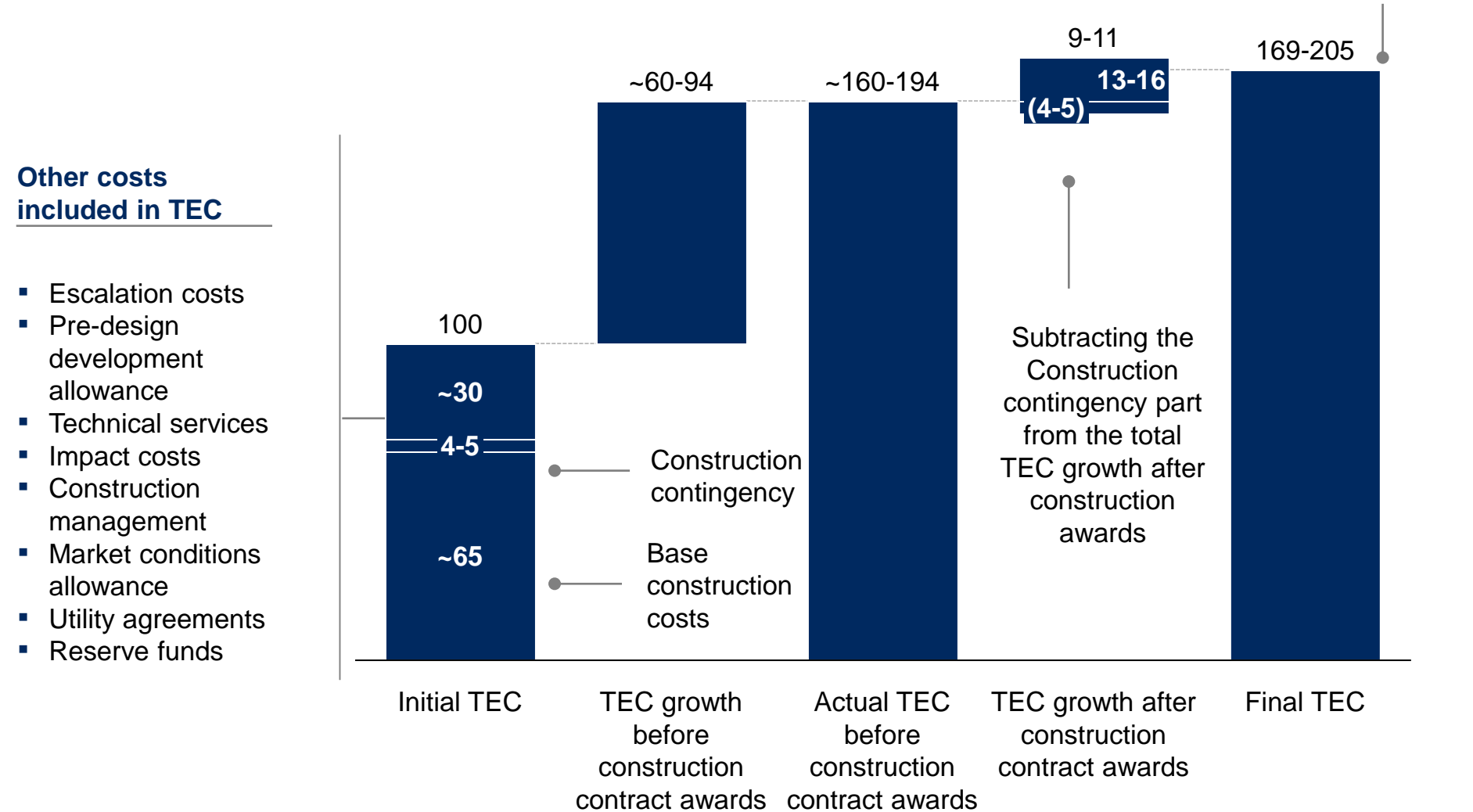
SOURCE: Outpatient workload projects (BDOC) taken from Healthcare Planning Model, June 2014; Space increases calculated as funded projects in the pipeline which were approved after the institution of the SCIP process (FY13-FY15)

NOTE: Figure 5-3 in Assessment K report

2C Cost growth for major projects occurs primarily in the design phase – before construction contracts are awarded

Total Estimated Cost (TEC) growth
Percent of initial costs

Average of latest projects surveyed ~187% or +87% above initial TEC



SOURCE: GAO-13-302, VA budget requests 2006-16, internal VA project status update as of April 30, 2015, project update documents for Palo Alto Ambulatory Care/Polytrauma Rehab project

NOTE: Figure 6-14 in Assessment K report

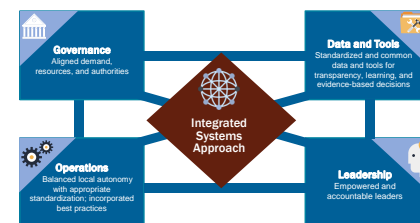
Assessment K Recommendations

Overhaul VA's capital program and supporting organization by consistently deploying world class practices which could result in savings between 25-35%, addressing some, but not all of the capital constraints VA faces:

- **Improve project selection and refine the project portfolio.**
 - Refine the SCIP process to ensure scoring criteria are reflective of the most critical elements that contribute to Veteran care
 - Strengthen business case reviews and incorporate feedback on performance and outcomes from past projects into project prioritization
- **Streamline project delivery across all construction types.**
 - Modernize and rationalize design standards
 - Implement leading edge project controls include a stage-gate process to manage change
 - Restructure project delivery teams with clear roles and responsibilities, well-defined handoffs, and adequate staffing levels
- **VHA should ensure proposed projects make the most of existing infrastructure.**
 - Incorporate a total cost of ownership assessment approach into design, capital planning, and facility management to optimize capital and operating costs simultaneously
 - Regularly evaluate underutilized and vacant space through the space planning process to identify opportunities for increased utilization or to actively divest unusable properties

Deploy strategic changes that address how and where to best serve Veterans and how to maximize operating efficiency to yield significant improvement in the remaining capital funding gap

- Maximizing operational efficiency (e.g., extending operating hours, improving scheduling)
- Reassess how and where to best serve veterans (e.g., geographic realignment, partnerships)
- Explore alternative vehicles for capital delivery (e.g., establishing innovative public-private partnerships)





Assessment L: Leadership

“(L) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.”

Summary findings

- Our efforts yielded a complex portrait of leadership and culture at VHA. Leaders are operating within a deteriorating atmosphere, under intense public scrutiny and with significant cultural and operating challenges. Findings include:
 - 1 An expanding scope of VHA activities has led to confusion around priorities and strategic direction
 - 2 The VHA organization is intensely, unnecessarily complex due to lack of a clear operating model, limited role clarity, fragmentation of authority, and overlapping responsibilities
 - 3 The broader VHA culture is characterized by risk-aversion and distrust, resulting in an inability to improve performance consistently and fully across the system
 - 4 VHA leadership faces a workforce that appears to be steadily losing its motivation
 - 5 The performance of a particular VAMC hinges to a large degree on the capability of its Director and the executive leadership team; yet these leaders are “on their own” in many ways
 - 6 VHA leadership attention is consumed by addressing crises that have occurred in the past, at the expense of preparing for tomorrow’s opportunities
 - 7 The leadership pipeline is not robust enough to meet VHA’s current and future needs

2 Entities with authority for VAMC accountabilities

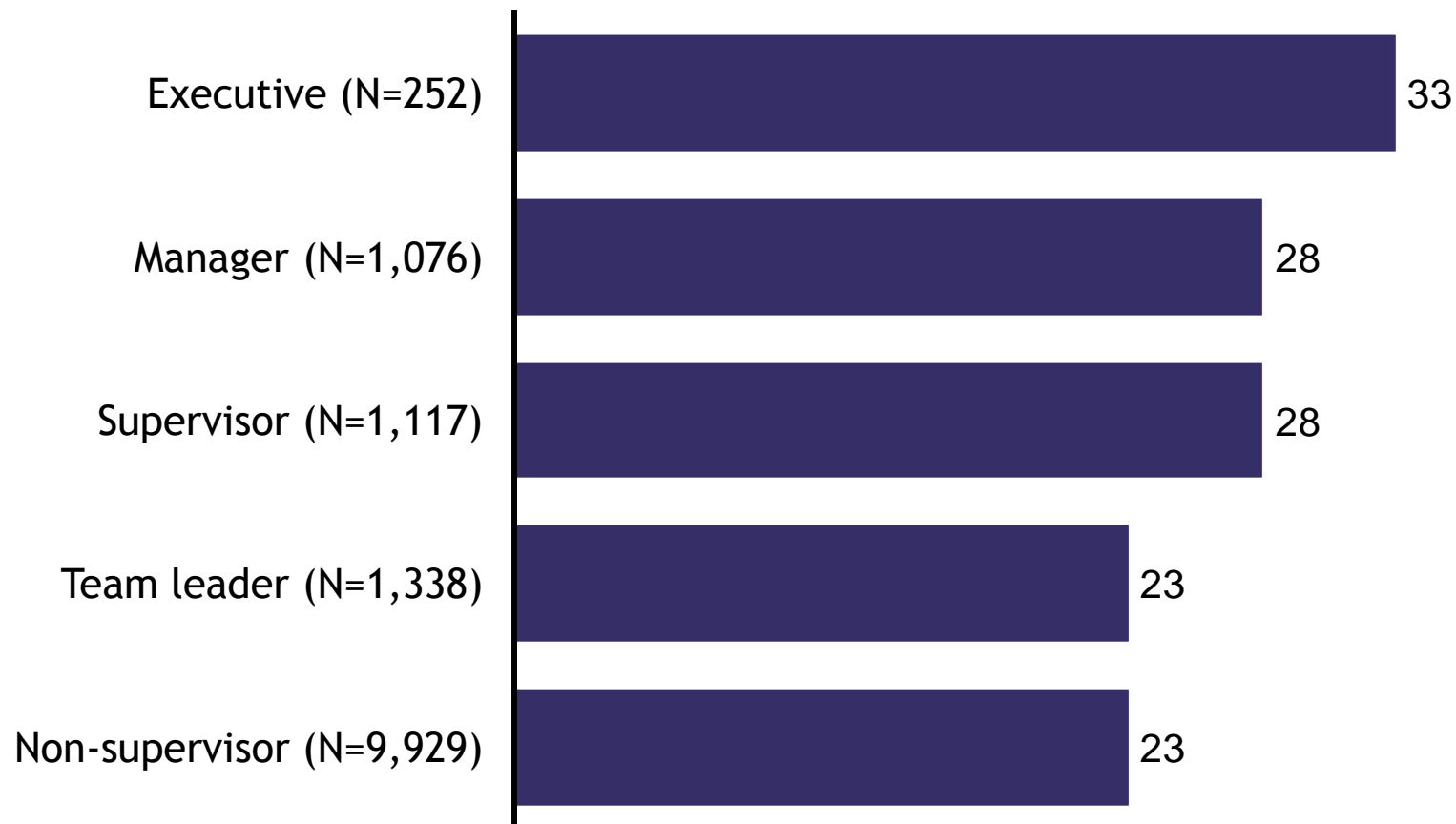
Area for which VAMC is accountable	VAMC	VISN	VHACO	VACO	Union	Congress	Other
Employee experience	✓				✓		
Culture	✓	✓	✓	✓	✓	✓	✓
Operational excellence	✓	✓	✓				
Fiscal stewardship	✓	✓	✓			✓	
Veteran experience	✓	✓	✓				
Facility	✓	✓	✓	✓	✓	✓	
Compliance with directives		✓	✓	✓	✓	✓	
Physical safety	✓	✓					
External affairs		✓	✓			✓	✓

SOURCE: VHA interviews, 2015; USAjobs VAMC job descriptions

NOTE: Figure 10-2 in Assessment L report

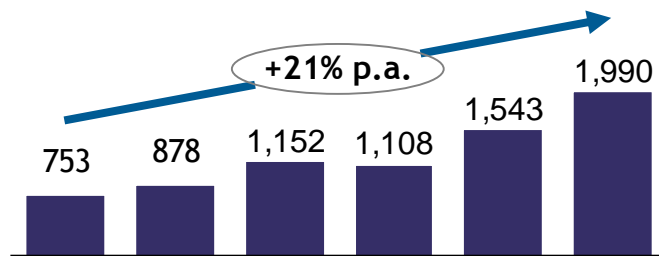
② Only one in three VHA executives believes employees have sufficient authority, and this decreases as level of responsibility decreases

Percent of respondents who frequently observe the following behavior:
“Employees within the organization have sufficient authority to make decisions”

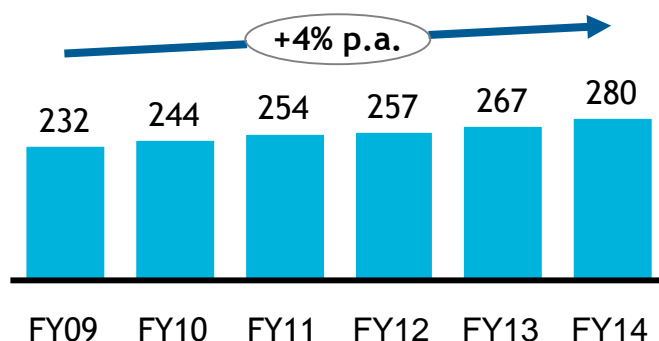


2 VHACO Program Office FTE growth has outpaced other VHA populations

VHACO Program Office FTE¹, FY2009-FY14
FTE

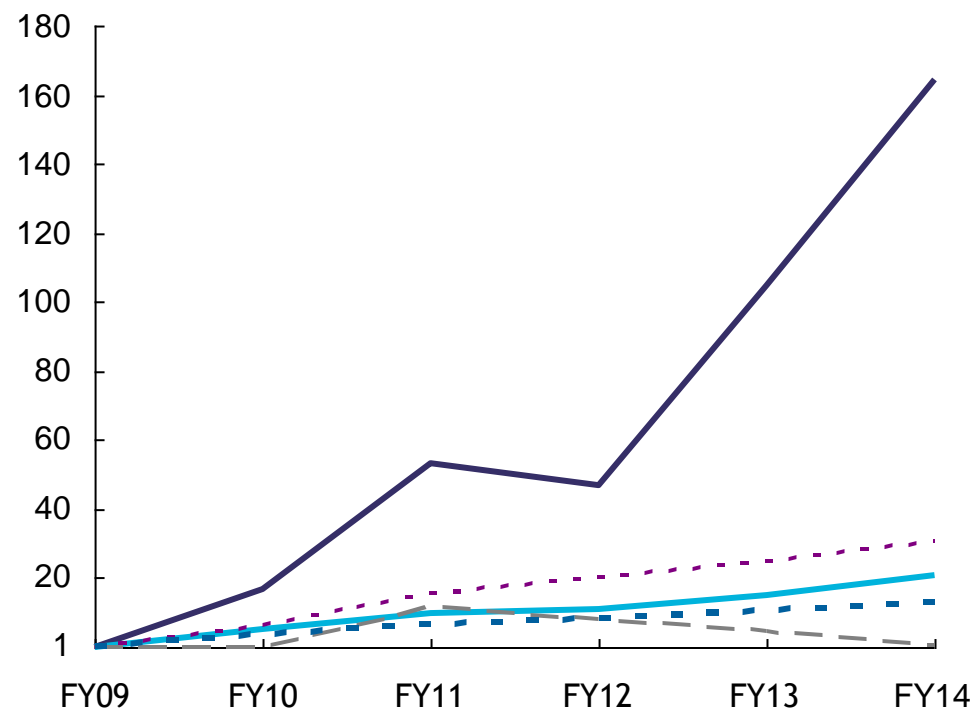


VHA FTE total, FY2009-FY14
FTE, thousands



Growth of VHACO, FY2009-FY14

Growth, percent; normalized to FY09



1 Station 101 only; excludes CMOP, CPAC, Business Office, and other similar direct service programs

SOURCE: VA, Task Force on Improving Effectiveness of VHA Governance, 2015

NOTE: Figure 13-1 in Assessment L report

3 When compared to peers and the global benchmark, VHA lags in every outcome

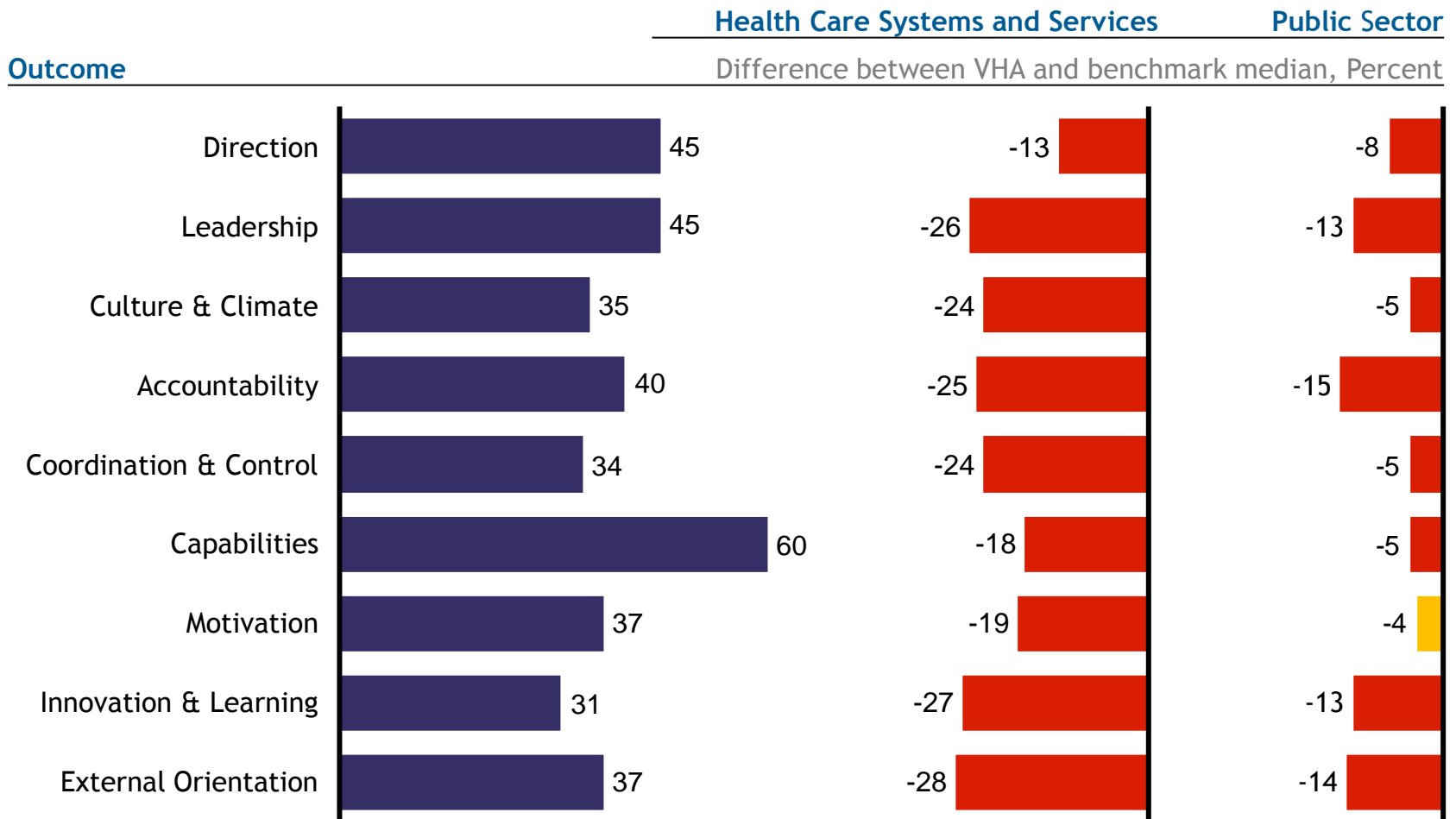
Percentage agreement on outcome effectiveness

Global benchmark

Top quartile
Second quartile
Third quartile
Bottom quartile

Comparison to benchmark

Stronger (> +5)
Comparable
Weaker (< -5)



SOURCE: VHA OHI Survey 2015 (N=13,712); Health Care Systems and Services (N=40,437, no. surveys=33), Public Sector (N=47,159, no. surveys=27)

NOTE: Figure 7-5 in Assessment L report

3 Difference between current and desired values

Top 15 current and desired values

CURRENT VALUES Where we are today ...	CURRENT & DESIRED VALUES What we'd like to continue ...	DESIRED VALUES Where we'd like to be ...
Bureaucracy Internal politics Having a noble purpose Slow-moving Hierarchical Inconsistent Silos Making a difference Contributing to the greater good Conflict	Veteran focus Being of service to others Caring Commitment ¹ Advocacy ¹	Accountability Continuous improvement Being Collaborative Excellence ¹ Efficiency Integrity ¹ Well organized Respect ¹ Employee focus Professional growth

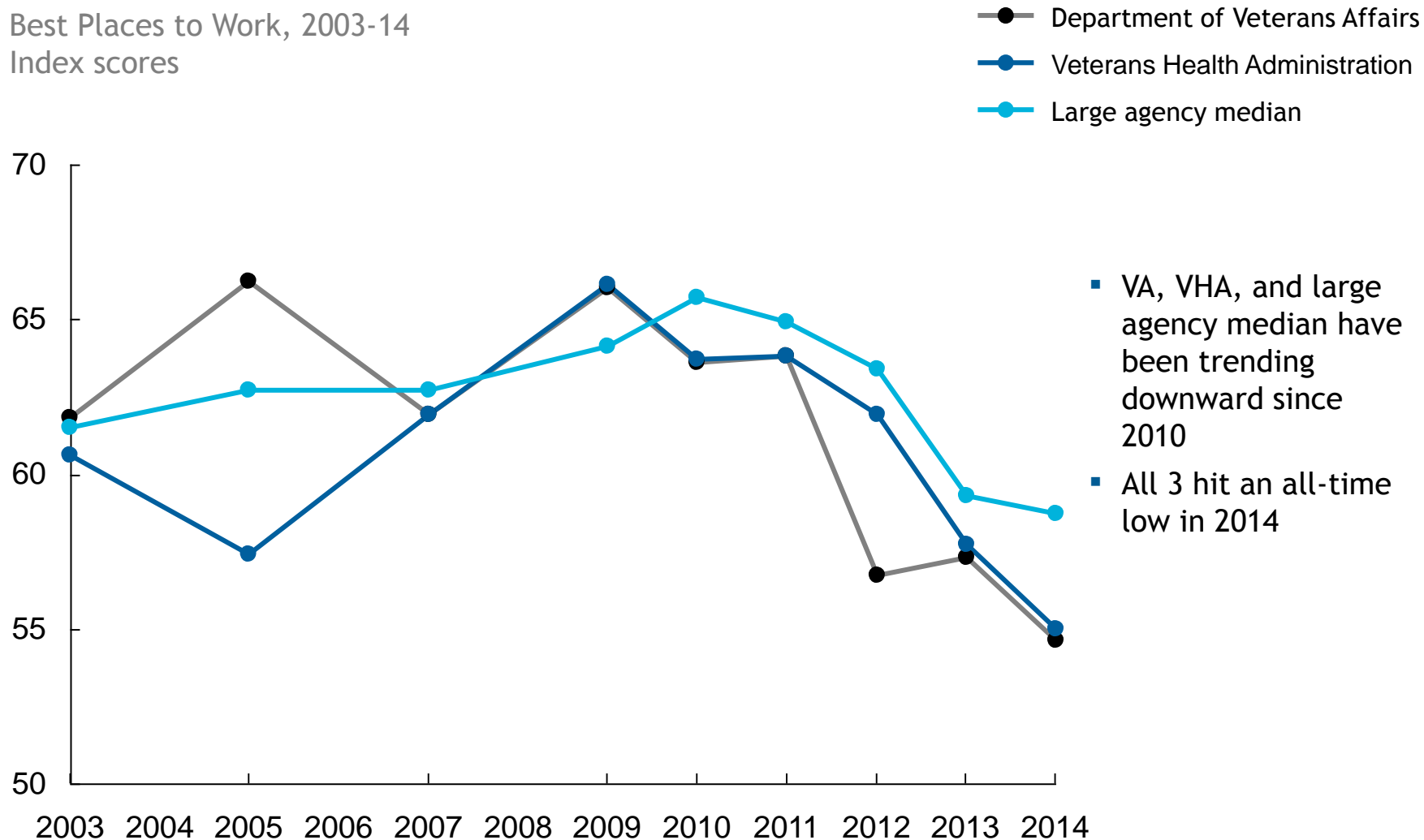
1 ICARE value

SOURCE: VHA OHI Survey 2015 (N=13,712)

NOTE: Figure 7-2 in Assessment L report

4 In Federal Best Places to Work, VA and VHA have been lower than the large agency median since 2010

Best Places to Work, 2003-14
Index scores



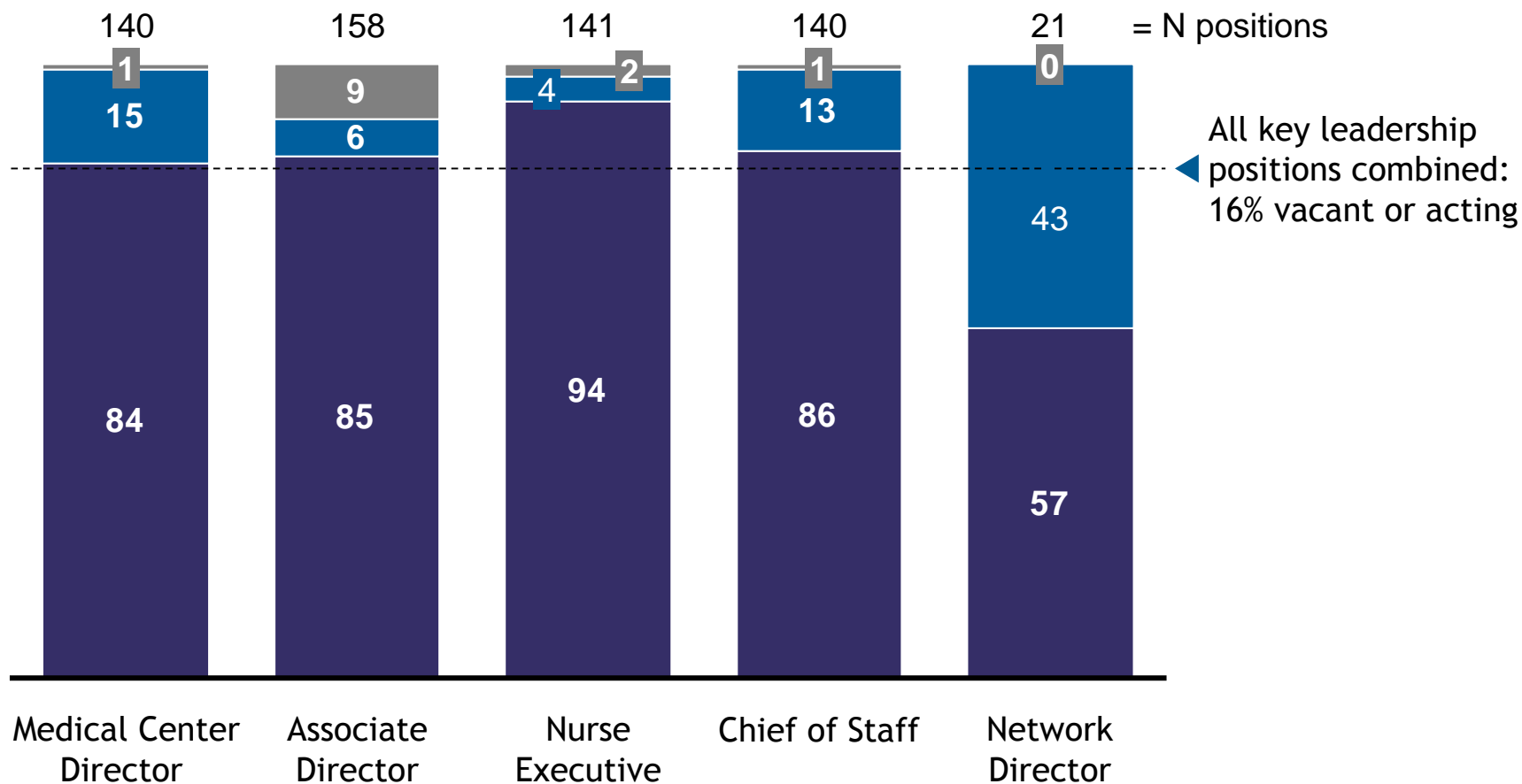
SOURCE: Partnership for Public Service and Deloitte, The Best Places to Work in the Federal Government, 2014

NOTE: Figure 8-4 in Assessment L report

7 16 percent of key VHA leadership positions are vacant or are filled with acting leaders

■ Vacant
■ Acting
■ Filled

Percentage; as of March 9, 2015



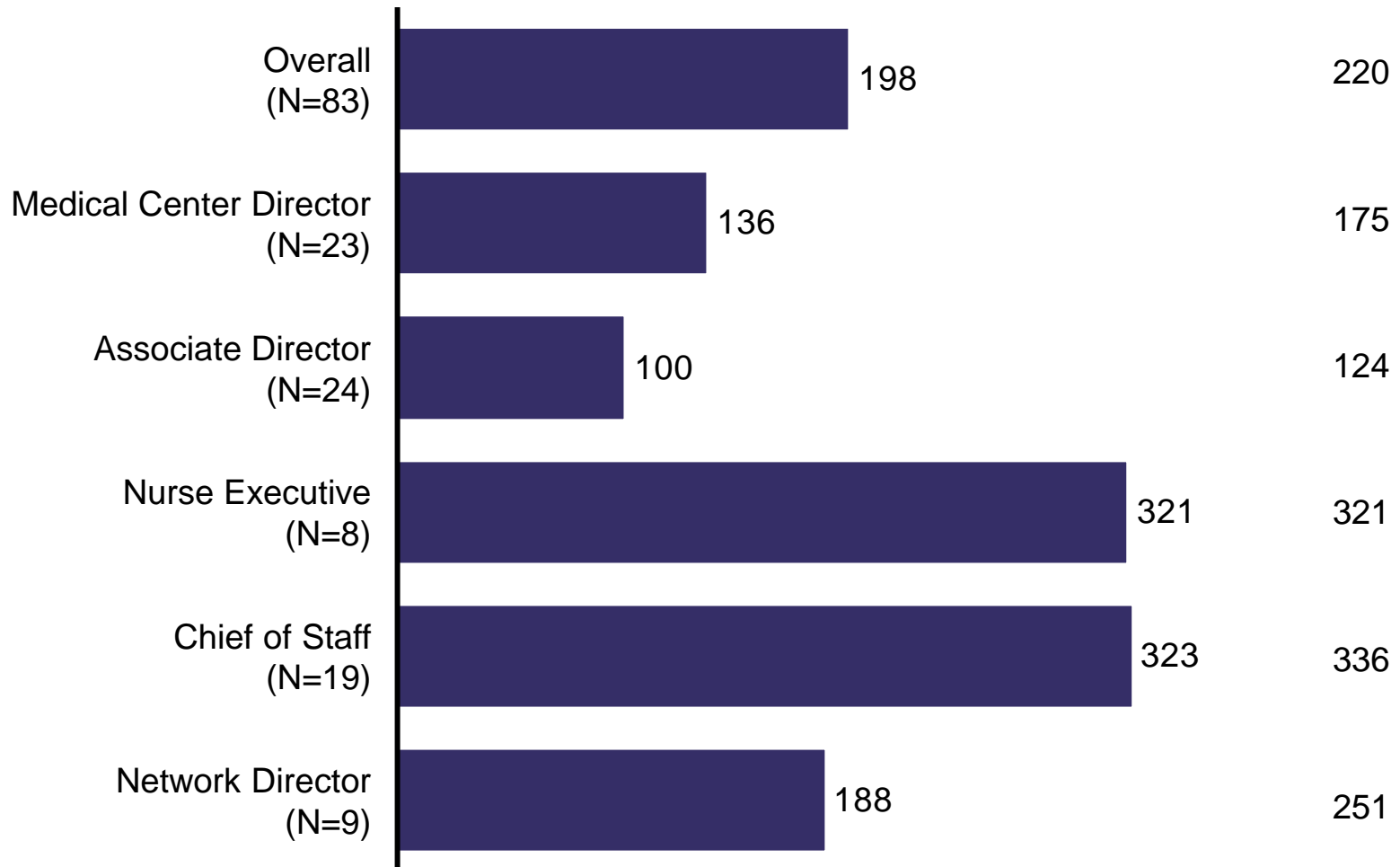
SOURCE: VHA Office of Workforce Services, as of March 2015

NOTE: Figure 5-1 in Assessment L report

7 Currently vacant key VHA leadership positions have been open for a median of 198 days

Days vacant, median

Days vacant



SOURCE: VHA Office of Workforce Services, as of March 2015

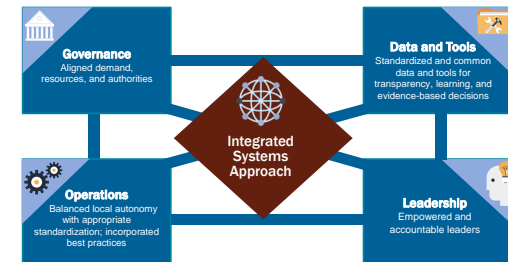
NOTE: Figure 5-2 in Assessment L report

Assessment L—Leadership

Immediate action is required to address these challenges:

- Galvanize VHA leaders around a clear strategic direction
- Stabilize, grow, and empower leaders
- Redesign VHA's operating model
- Focus and simplify performance management
- Rebuild a high-performing, healthy culture
- Redesign the HR function as a more responsive customer service-focused entity

Addressing these challenges will require a fundamental shift achieved through a bold, integrated, multi-year transformation sequenced in a thoughtful manner





Preconditions for implementation to be successful

- Clear definition of where the organization is headed, grounded in VHA's mission and strategic direction
- Support and commitment from senior leadership in the field and in Central Office, bolstered by strong field involvement
- Congressional support
- Capacity, perhaps created by scaling back or stopping select initiatives that are less important to strategic direction
- A formal change program housed in a central transformation office, with authority and resources to support the transformation throughout the organization
- A clear action plan, with milestones and timelines
- Demonstrated progress, early wins, and ongoing monitoring
- Sustained and consistent leadership



Assessment H: Health Information Technology

Conduct an assessment of the “information technology strategies of the Department with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by the Department, especially those strategies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Department in Department or non-Department facilities.”



Assessment H: Health Information Technology

Summary Findings

- Ineffective implementation of strategic plans and health IT management
- Organization and processes not tuned to the scale and complexity of the VA's IT challenges
- Complex IT infrastructure and, inconsistent clinical documentation processes are causing VA to lag private sector in using IT to improve healthcare and Veteran satisfaction

Specifically:

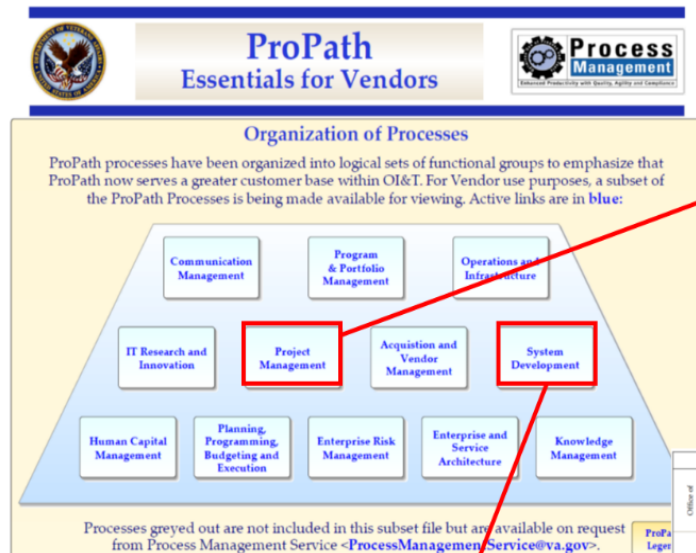
1. Strategic Planning: Inadequate collaboration between VHA and OI&T
2. Project Management and Execution: Development and program management process is overly complex, lacks integration plans and emphasizes schedule-driven results
3. Infrastructure Complexity: Large heterogeneous mix of technology built over decades and managed across numerous individual projects
4. Increasing O&M Cost: 85% of IT budget allocated to maintenance
5. Doc. & coding: Lack of standards, data collection and delayed improvements

Strategic Planning: VA's ability to implement its strategic plans and deliver new capabilities for its VistA health care system has stalled



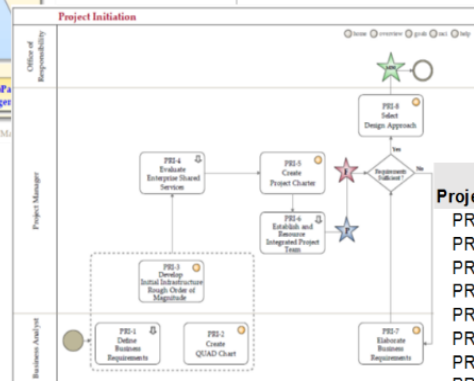
The health care systems are in danger of becoming obsolete

Complex Project Management Processes: Overly demanding processes for project management stymie delivery



Project Initiation	8
Project Launch	5
Project Monitoring and Control	9
Change Management	6
Configuration Management	5
Project Planning	9
Project Shut Down	7
Restart Paused Projects	6
Start Subsequent Increment	10
Project Closure	6
	71

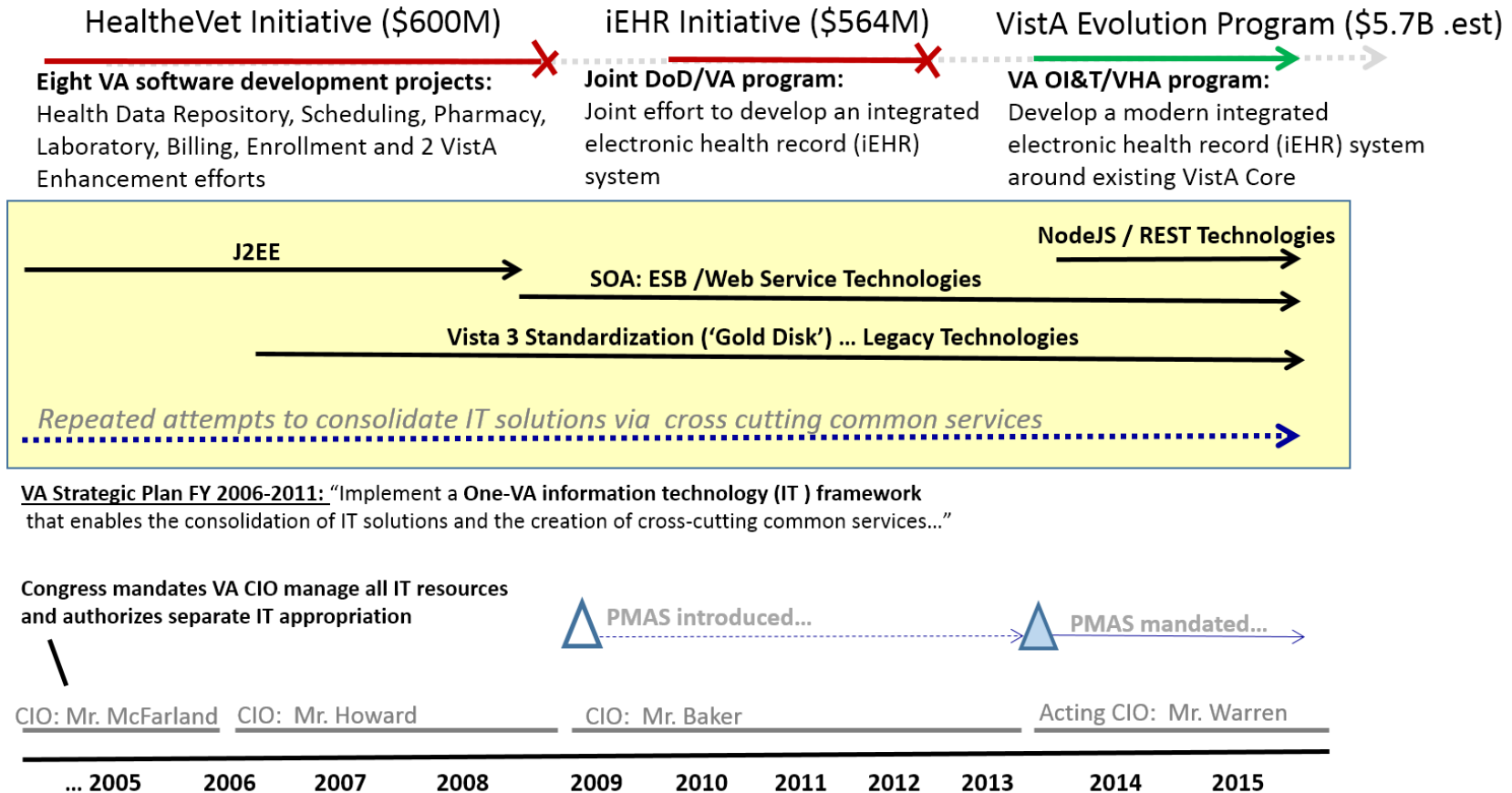
Assessment and Authorization Process	10
DoD/VA Authority To Operate Reciprocity	2
Implementation Management	13
Independent Test and Evaluation	6
Product Architecture	10
Product Build	14
Product Design	9
Product Documentation	8
Product Support	2
Release Management	3
Requirements Elaboration	5
Test Preparation	9
	91



	#Sub Activities	Artifacts Created
PRI-1 PRI-1 Define Business Requirements	4	4
PRI-2 Create QUAD Chart	1	1
PRI-3 Develop Initial Infrastructure ROM	1	3
PRI-4 Evaluate Enterprise Shared Services	17	23
PRI-5 Create Project Charter	1	1
PRI-6 Establish and Resource Integrated	8	2
PRI-8 Select Design Approach	1	2
PRI-7 Elaborate Business Requirements	1	3
	34	39

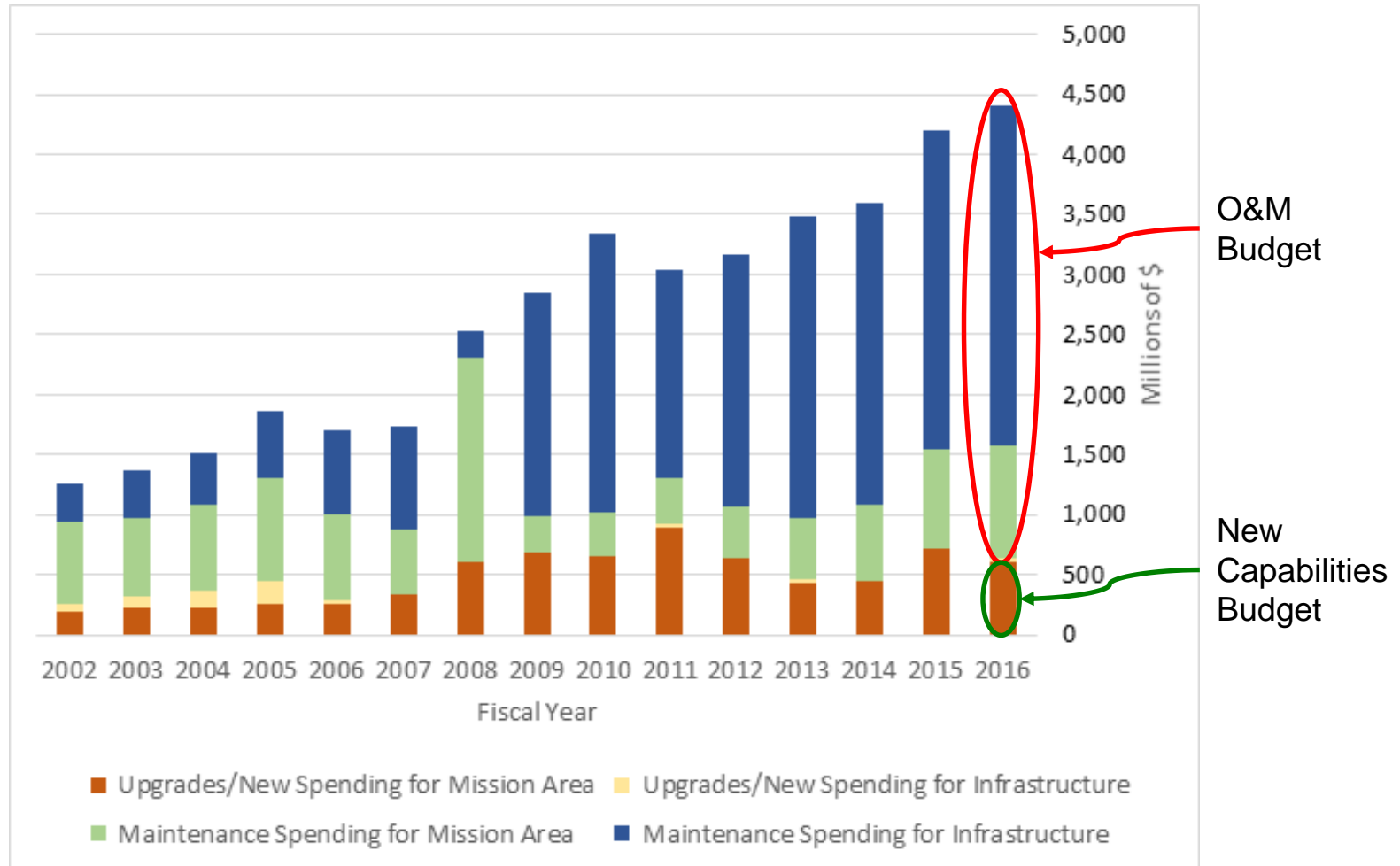
65 percent of builders indicated that PMAS has become overly complex and burdensome and reduces delivery of desired functionality

Infrastructure Complexity: Legacy IT infrastructure is very difficult to change, extend, and modernize



Technology and leadership churn and site-customization of VistA contribute to complexity

Increasing O&M Cost: 85% of FY16 IT budget allocated to maintenance



Little funding remains for IT and software improvements



Documentation & coding: Lack of standard clinical documentation deters electronic health record analytics and exchange

- Clinical documentation tools do not collect key data in a consistent or standardized manner
- The quality of VHA clinical documentation produced by current systems does not support accurate and optimal analytics or clinical decisions.
- Current VHA clinical documentation practices do not adequately support accurate measurement of quality, safety, or performance metrics
- The standards and terminology used by VistA and CPRS do not suffice to enable interoperability DoD, private sector providers, and payers
- Clinical imaging and document archival systems are functionally adequate; however, accessing raw images and reports from within clinical workflow processes can be awkward and often requires users to navigate multiple systems

Failure to adequately use coded terminologies and standards reduces VHA's ability to measure outcomes of care and learn from them - impeding the creation of a continuously learning health system

Best Practices Were Identified

BACKGROUND

- Faced with declining Veteran population and VISN implemented hub and spoke model
- Similar VAMCs provide standard services with easy access
- Pittsburgh VAMC handles high-acuity cases to maintain quaternary care certification

VISN 4



NEVER SAY NO

Pittsburgh VAMC overhauled rooms, processes, IT reporting, and collaboration with University of Pittsburgh Medical Center to ensure available bed space for all inpatient requirements

PATIENT SATISFACTION

Multiple, frequent approaches to assessing Veteran satisfaction:

- Patient questionnaires upon departure
- Representatives roaming the floors interacting with patients
- Town Hall meetings

STAFF ENGAGEMENT

- Lean approach to process improvement enhanced hiring, food quality and staff engagement
- Periodic forum titled "Expoexceptional" provides staff the opportunity to propose improvements based on their experiences and ideas

FULLY INTEGRATED VISN IT SYSTEM

- Real-time copy of all VISN operational data
- Peers can compare satisfaction and quality results
- Evidence-based feedback available to enable process changes in real time

NOTABLE OUTCOMES

- 5 of the 10 VAMCs with the most SAIL scores in the top 10% are located in VISN 4
- Erie VAMC received VA performance excellence awards in 1998 and 2000 and The Joint Commission Top Performer award in 2011 and 2012



While best practices exist in selected pockets, communications and support for implementation at scale appears to be a challenge

IT Solutions through the Lens of the Integrated Systems Approach



Governance

- Lengthen tenure of key leadership positions, including VA CIO
- Designate a dedicated VHA CIO to manage and advocate VHA's IT needs



Data and Tools

- Perform a comprehensive cost-versus-benefit analysis between a commercial off the shelf EHR and continued in-house custom development of VistA EHR
- Create real-time data capacity with standardized enterprise data to enable analysis of trends, best practices, and efficacy of new treatments
- Implement standardized data exchange with DoD, payers, and private providers



Integrated Systems Approach



Operations

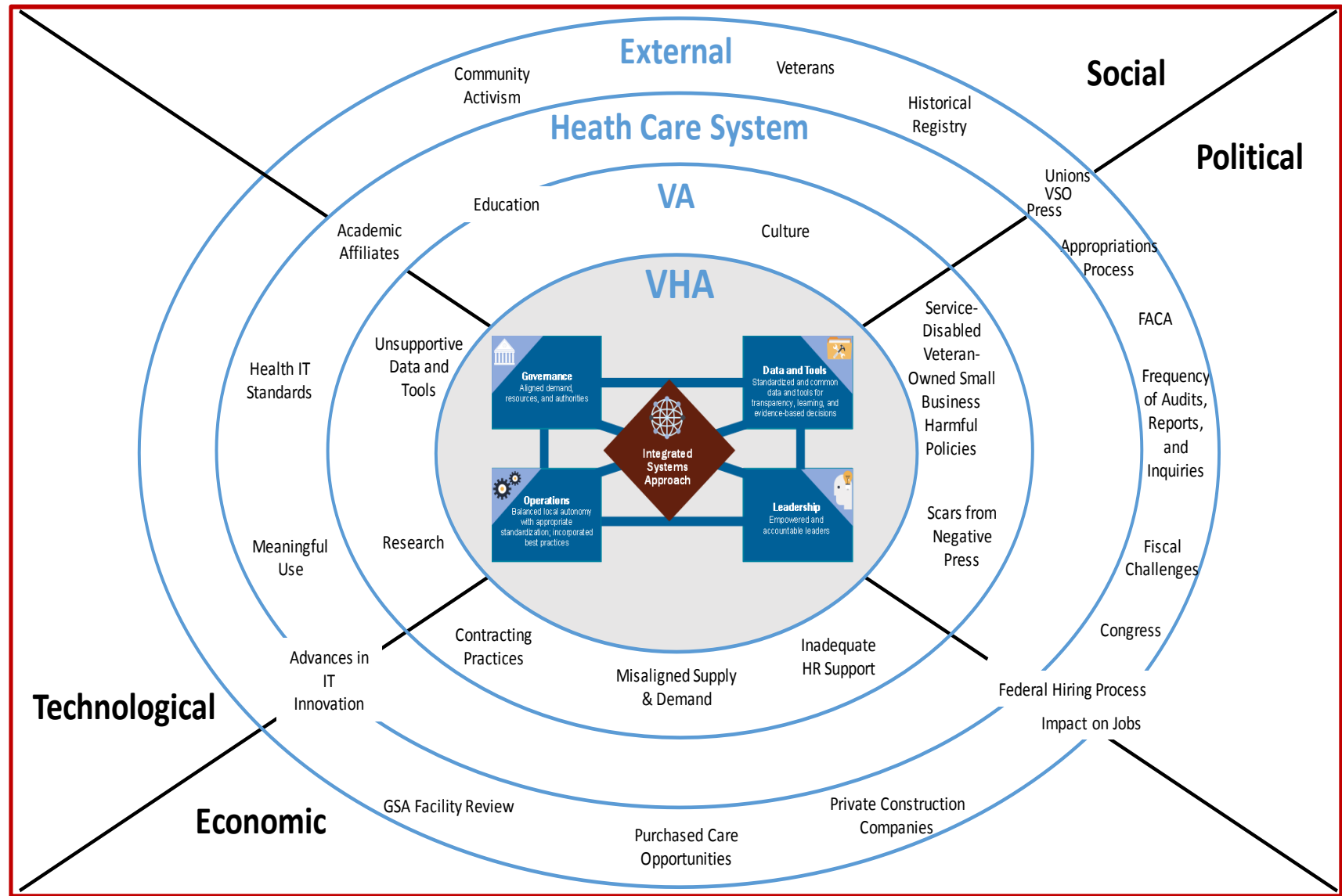
- Implement a broad process, inclusive of clinicians, to pursue requirements that support clinical documentation best practices and improved functionality
- Build and maintain a skilled health informatics workforce
- Enhance technical support to Veterans for home telehealth
- Publish limited, strategic measures (e.g., access, quality, satisfaction)



Leadership

- Convert project-focused IT approach to IT service management model with customer focus
- Create effective VistA program organization and staffing
- Develop decision support capabilities that monitor quality, patient satisfaction, claims, payments, access, supply, and demand

The Ecosystem of the Veteran's Health Care System





Questions?